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The Longitudinal Intervention Model

Phone interventions to help trauma and loss survivors

Sigal Haimov

The Longitudinal Intervention Model- Phone interventions to help trauma and loss survivors

Proefschrift ter verkrijging van de graad van doctor
aan Tilburg University op gezag van de rector magnificus, prof. dr. E.H.L. Aarts,
in het openbaar te verdedigen ten overstaan van een
door het college voor promoties aangewezen commissie
in de Ruth First zaal van de Universiteit op
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The *L*ongitudinal *I*ntervention *M*odel

Phone interventions
to help trauma and loss survivors

A Dissertation by

Sigal Haimov

Tilburg University

Graduate School for Humanities

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Abstract

Israeli society has been coping for years with multiple-victim incidents, outcomes of terror and wars. Likewise, in recent years western countries have also started to realize that their populations are and will continue to be affected by terror and its mental health effects.

The present study explored the practice of phone interventions and trauma/loss treatment by focusing on the use of helplines to provide mental-health services. It investigated an Israeli helpline (NATAL's helpline) which provides treatment to survivors of trauma and loss, and operates on the basis of a unique model of intervention – the LIM (Longitudinal Intervention Model).

The field of tele-medicine offers different and diverse services, and there is a disagreement among scholars regarding the definition, philosophy and practice of these services. Moreover, the NATAL helpline and the LIM provide a service which contains elements that are more typical to therapy than to crisis intervention, and also include principles which are considered unacceptable to tele-medicine.

The present study examined the helpline impact through identifying the characteristics of the population which is affected by the helpline. It also explored the therapeutic process, by focusing on the characteristics and the effect of the intervention and the model it is based upon. Further, it evaluated the therapeutic outcome.

Quantitative and qualitative methods were used to gather information of the helpline's calls, callers and clients (years 1998-2014). Data included case files, in-depth interviews, focus groups and personal records (letters). The research questions were examined from two perspectives - the perspective of the helpline clients, and the perspective of the helpers/the helpline specialists.

The results indicate that following trauma/loss, there are many people in Israel in need of mental health services and emotional support, and that helplines can provide services to large populations – during crises and during the aftermath.

The treatments available for trauma and loss span a variety of psychological approaches. The results support past findings which showed that therapeutic elements such as creating a safe place, providing understanding/empathy/containment (non-judgmental), encouraging emotional expression, and offering new perspectives/insights – are the significant components which contribute to successful treatment.

The present study showed that interventions done by the telephone specialists, according to the LIM, result in significant therapeutic impact: there was a general decline in functioning problems, an

improvement in the severity of symptoms of the clients, and a reported improvement in clients' well-being and better social/familial relationships.

This study showed that it is the synergy between the medium (phone) and the model (LIM) which is responsible for the positive outcomes that were found during this research. Specifically, the element of constant reaching-out to clients, however uncommon to therapy and helplines, was found to be a crucial component which is viewed by clients as very helpful.

The presented therapeutic outcomes indicate that the LIM may be an additional or alternative mode of mental health service for trauma/loss survivors, which can help promoting their recovery or well-being. It also points to the necessity of the mental health profession to search for and develop non-stigmatic approaches and service-deliveries in order to enable more people to receive help.

Acknowledgements

I would like to take this opportunity to acknowledge the contribution of people, without whom this thesis would not have been completed. I wish to express my deepest gratitude to all those who assisted me through this dissertation process in some way. Such significant work requires the effort and support of many assisting in its development and culmination, and I am thankful for being surrounded by an amazingly supportive group of people.

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Last, but never least, to my best friend, Yael Gilad – the vicious terrorist who killed you, could never kill your memory and your legacy. This work honors you.

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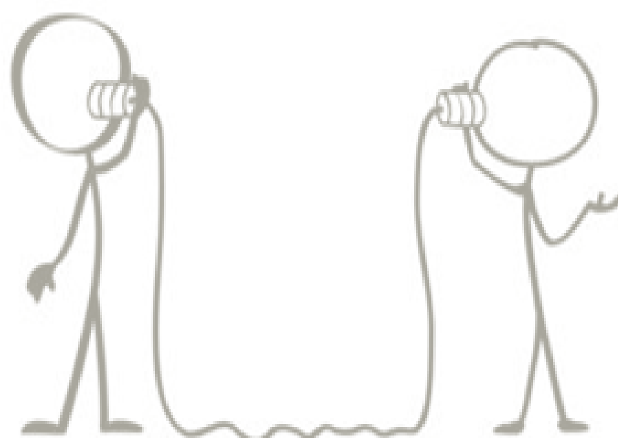
PART I

Background of the Thesis



Chapter 1

General Introduction

'You must be the change you wish to see in the world'

Mahatma Gandhi

(Gandhi & Parel, 1997)

My name is Sigal Haimov. In 2014 after several years of contemplating and considering the possibility of furthering my professional education I decided to look for a university where I could study for a PhD. This decision has led me to a more profound process of exploration and reflection regarding the milestones of my personal and professional life, the people and events that influenced and shaped my life and the reasons behind the major choices I have made:

I come from a long line of socially engaged women that were conscious and sensitive to the needs of the people in their community: my great grandmother used to take needy people to her home, feed them and help them to get back on their feet. She was known in her village as the woman who does the unconventional and unthinkable – confronting the rich man of the village saying: "you have more than enough therefore give the poor people a few of your sweaters so that they don't freeze"…

My grandmother was known as a mediator in her community. People shared their struggles with her, knowing she would provide a shoulder to cry on and a sound advice. Like her mother, she provided a warm home to those in need.

My mother, very much like her mother and grandmother is involved in her community – volunteering, doing charity work and fighting for justice to those who couldn't fight for themselves.

I was raised with the legacy of these great ladies, cherishing kind humane behavior and understanding the importance of social support. In accordance of this legacy, I volunteered in different projects all through elementary school and high school. I was involved with a youth movement (girl scouts) both as a participant and later as a group leader.

After high school, as most Israelis I served 2 years in the military as a diagnostician and was in charge of diagnosis and interviews of candidates for recruitment to the Israeli Defense Force. That was the first time I was trained in psychology and practiced one aspect of this field, and it led me to the understanding that I am drawn to social sciences and want to study it. I contemplated between social work and psychology and decided to join many of my peers in the military unit and study psychology. I studied 3 years for a Bachelor's degree and had some doubts about continuing for a Master's degree in clinical psychology – mainly because I felt the focus is with mentally disturbed people, while I was more interested in people with "normal" problems – I felt I could help them more than I could assist the mentally disturbed. I decided to take some time off university and to try to get more information and experience that will help me make the "right" decision.

While searching for a path to the future I looked for a volunteering position and by chance came across the world of helplines. One might say I was destined for phone interventions….

My personal journey in the world of helplines began in 1990 (after finishing the studies for a Bachelor's degree in psychology). I started volunteering at the helpline in ELI- Israel Association for Child Protection. I went through a selection process followed by training and volunteered for about a year before I was offered the position of the helpline manager. Being young and naïve enough I accepted the challenge, and followed the footsteps of those who taught me everything I knew at that time about helplines.

I served as the helpline manager for 4 years during which I "learned and adhered to the rules of the profession":

There were two types of calls to the helpline – the most common were reports of suspected child abuse. The callers were anonymous, the volunteers encouraged them to tell the story and share as much information as possible and the conversation focused on gaining a better understanding of the situation and reaching an agreement on the next steps. Usually after the conversation the case was reported to Social Services.

The rarer type of calls was calls from adults who were abused as children and wanted to share their painful memories or seek help. These were very emotional calls, all of them started anonymous and most of them ended anonymous. The volunteers' role was to empathically listen, show understanding and support and find out if the caller wanted any practical assistance. Usually at the end of the conversation callers received phone numbers of available therapeutic resources.

The rules of the "game" were very clear and well-kept: both parties didn't see each other nor identified themselves. The volunteers didn't disclose anything about themselves while callers were expected to share intimate information, although they could choose when, what and how much they wanted to share. For both parties this was a single encounter without any continuity or follow-up.

I learned that it is much easier for people to seek assistance via phone than face-to-face. I found out that people were comfortable talking to strangers and found solace by simply sharing their story. I was surprised to learn that most callers wanted to talk with a sympathetic volunteer rather than with professional personnel.

During these four years I realized that there were many children being abused while we received only small amount of reports. The awareness to this gap made me frustrated and I started to think of ways to bridge this gap. That led me to spend the next four years as Prevention Program Manager – a project I created in order to reach-out to children in the community (schools and youth centers) and offer assistance to those we detected as being child abuse victims. Through this project I also taught professionals working with children how to identify children being abused and how to reach

out to them. This project involved tens of thousands of children, parents and professionals, all over the country.

The important lessons I learned through this project were that many people in every community carry a heavy burden of bad experiences or memories without sharing it with the people closest to them, and that many people will not seek help unless you reach-out to them and offer assistance. Maybe the most important lesson was that people made the first step to healing only after their suffering was recognized and validated.

In 1997 a major event changed my life: My best childhood friend, Yael Gilaad, who was like a sister to me, was murdered in a terrorist attack while she was sitting in a café in Tel Aviv.

The Café Apropo bombing occurred on March 21, 1997. At 1:45 p.m., a suicide bomber detonated an explosive device which was concealed in a handbag shortly after sitting at a table on the terrace of the packed Apropo cafe, in central Tel Aviv. The cafe was filled with families celebrating the Jewish holiday of Purim. The blast, which was heard throughout the downtown area, blew out windows of nearby buildings and vehicles. Furniture and people were hurled meters from the scene, some into the middle of the street.The force of the explosion injured 48 among them were several children in their Purim costumes. Three young women in their early 30s were killed:

Anat Winter-Rosen, a Herzliya lawyer and the mother of a six-month-old baby-girl who was also wounded, died from her wounds at Ichilov Hospital. Dr. Michal Avrahami, 32, of Tel Aviv, a radiologist, died shortly after being taken to the hospital. She was three months pregnant with her first child. Her husband and mother-in-law were moderately wounded. The third victim, died at the scène was Yael Gilad, 32, a social worker from Neve Monosson.

This sudden, shocking loss seemed to me like the end of the world and my life. I was grief-stricken, heartbroken and inconsolable. Everything seemed insignificant and worthless.

Similar to many other people who have experienced trauma and loss I went through a grieving process struggling with everyday life – occupation, personal relationships, sleep, leisure etc. In order to better cope and start healing I had to find new meaning in my life.

I heard from a friend that two people, Yehudith Yovel Recanati and Dr. Yossi Hadar were thinking about founding a nonprofit organization that will provide assistance to victims of terror and war and for the first time in months I felt something other than despair – I was interested. I have previously met Mrs. Recanati while I was working in ELI so I reached out to her, shared with her my tragic experience and asked if I could volunteer to help them form this future organization. I joined the

steering committee and for a year was part of a think-team that created and launched Natal - Israel Trauma Center for Victims of Terror and War.

This journey in the last 19 years has been meaningful, enriching and healing. It involved a lot of reflection, learning and developing on both personal and professional levels. Many people were part of this journey, sharing experiences and insights. It is time for me to share the experience of my journey, the understandings it brought and the visions it originated.

This work is inherently connected to its environment – the geographic area of research is the state of Israel, the sociocultural target population is the Israeli-Jewish public, the study population focuses on one organization – NATAL, and one service – the helpline and its callers/beneficiaries. This might seem as a small restricted entity, but I believe that alongside some of the unique characteristics there are also global facets, phenomena and implications.

It is a great opportunity to explore some of the less-known aspects of this field that may lead to and contribute to "understanding society" in accordance with the Tilburg University motto.

'Every secret of a writer's soul, every experience of his life, every quality of his mind is written large in his works'.

Virginia Woolf

(Woolf, 2013)

Chapter 2

Aims and Outline of the Thesis

Aims of the thesis

'We shall not cease from exploration, and the end of all our exploring will be to arrive where we started and know the place for the first time'.

T. S. Eliot

(Eliot, 2009)

The purpose of the present thesis is to inform the practice of phone interventions and trauma/loss treatment by adding to the existing growing findings concerning the use of helplines to provide mental-health services.

The aims of this thesis are threefold. The first aim of the thesis is to examine the helpline impact. More specifically, the study focuses on obtaining an elaborative description of the characteristics of Natal's helpline callers in order (a) to better understand the needs of callers and their reasons for calling, so that appropriate responses can be considered, (b) to identify vulnerable in-need of assistance populations, so that more attention and resources may be directed their way, and (c) to identify populations which are less likely to seek help and therefore need services to reach out to them.

The second aim is to gain a further understanding of the therapeutic process. More specifically, the study focuses on the characteristics and the effect of the intervention and the model it is based upon (LIM – Longitudinal Interventions Model).

The third aim is to further evaluate the therapeutic outcome. More specifically, the study focuses on whether and how the helpline interventions improve clients' mental health and well-being.

This thesis aims at gaining a thorough understanding of the questions in-hand, and therefore investigates the subject matter from two perspectives - the perspective of the helpline clients, and the perspective of the helpers/the helpline specialists. Yet, the study is conducted from a relativist stance. Although some conclusions are reached, these conclusions are based on the data provided by the participants and do not represent absolute 'truth'.

Finally, despite the growth of helplines, it is not necessarily the case that theorists have had the opportunity to achieve a deep understanding of what it means to perform phone interventions which are not crisis interventions per-se. With more organizations attempting to offer services over the phone and more demand for tele-medicine from clients, it is imperative to achieve additional theoretical framework and practical guidelines. So, in addition to the above aims, this study is also

interested in increasing awareness around the subject area within the mental-health profession so that professionals, mental-health training establishments and tele-medicine service providers can adopt a more informed perspective of this modality of practice.

Outline of the thesis

The thesis is divided into eight separate parts.

PART I presents the background of the thesis. Following an introductory chapter, **Chapter 2** details the aims and outline of the thesis.

PART II offers an introduction to NATAL. **Chapter 3** presents NATAL and the helpline, and provides a historic background of the Jewish people, describes the state of Israel and the Israeli military, and examines the psychological background of Jewish-Israelis. Then it focuses on the organization, NATAL, and the helpline which was investigated.

PART III provides the literature review. **Chapter 4** approaches the subject of trauma, loss and bereavement, along with their treatment. **Chapter 5** approaches the subject of phone interventions, referring to the emergence of telephone counseling services, the characteristics of telephone services, and acknowledges the advantages and disadvantages of phone interventions.

PART IV examines the helpline. **Chapter 6** describes the longitudinal interventions model (LIM) which is the basis of NATAL's helpline work, and outlines its three main elements: generating confidence and trust, retelling the story of the trauma/processing the story of the mourning, and reestablishing relationships between victims and their communities. **Chapter 7** observes the changes which were made over time in the model and at the helpline, referring specifically to the challenges of the first conversation, and to supervision and quality assurance.

PART V provides the research framework of the study. **Chapter 8** reviews the general evaluation of helplines, compares between the evaluations of face-to-face counseling to telephone counseling, details the difficulties in the study of helplines, and suggests possible research methods. **Chapter 9** outlines the methodology of the present study, describing the quantitative methodology and the qualitative methodology.

PART VI presents the findings of the study. **Chapter 10** provides the quantitative results. **Chapter 11** provides the qualitative results by categories.

PART VII provides a general discussion of the research findings. **Chapter 12** discusses the quantitative results and the qualitative results, and put them in a broader scientific perspective. **Chapter 13** describes the model adjustment which is derived from the research findings.

PART VIII concludes the thesis with a summary and conclusions. **Chapter 14** summarizes the research, addressing the three research sub-questions. **Chapter 15** presents an initial attempt of knowledge sharing and implementation of this model. **Chapter 16** completes the work of the study, providing conclusions and reflections.

The importance of this research

'It is a narrow mind which cannot look at a subject from various points of view'.

George Eliot

(Eliot, 2010)

This research may generate some important affects. First, a research project should explore a question which is significant to an understanding of a phenomenon that affects the lives of many people (Shlasky & Alpert, 2007). Today, as the world is facing the great problem of terrorism (Husain, 2012), the psychological and societal consequences of terror attacks, all over the globe, emphasize the relevance of this research. As suggested by Dechesne and Kruglanski (2004), in our times, insight into the phenomena of "terror" serves a greater purpose than the mere gratification of intellectual interest. Understanding what influence existential concerns constitutes not only a pertinent topic for scientific inquiry but also a direly needed area into which insights are needed given the current world's turmoil.

Second, the prevalence of mental illness and trauma in particular, demand current relevant research pertaining to services which can be offered to the vast population who is affected (Kazdin & Blasé, 2011). Hopefully, this research will contribute to the provision of supplementary and complementary services to survivors of trauma and loss.

Third, according to Sheehan (1996), research which contributes to the community's benefit is strategically significant. The present research investigates a suggested model which aims to improve the mental-health state of people suffering from trauma and loss. It is known that there is pattern of associations between mental disorders and a wider array of adverse life course outcomes that might be conceptualized as societal costs of these disorders, including reduced educational attainment, early marriage, marital instability, and low occupational and financial status (Kessler et al., 2009; Druss et al., 2009; Wittchen & Jacobi, 2005). Therefore, according to Kazdin and Blase (2011), the challenge for psychological interventions is to help reduce the burden of mental illness and related conditions both at the personal and societal level. If the suggested model can prove to reduce the burden of mental illness and related conditions, then this research is strategically significant in its contribution to the community's benefit.

Fourth, it has the potential to add to the existing literature by focusing on the direct link between terror/war trauma and the mental distress of survivors (Glass, Flory, Hankin, Kloos, & Turecki, 2009; Park & Ai, 2006), and by providing an assessment of the magnitude of these effects. It can also add to the optimal design of policies and practices for recovery.

Fifth, in the last two decades the literature dealing with tele-medicine has grown in breadth and depth, yet there is still a knowledge gap, which is described by Goodall (2000) as a topic or area which hasn't been explored enough or should be addressed differently. One of the main goals of this research is to explore the opportunity to provide an unusual mental-health service – longitudinal telephone interventions, which allow for a therapeutic process, wider and deeper than crisis interventions. Therefore, this research may add to existing knowledge of several scientific fields: mental health (trauma and loss survivors), social studies, and tele-medicine.

PART II

Introduction to

NATAL

Chapter 3

NATAL and the Helpline

This chapter introduces the organization and the service which are investigated in this research. It begins with a portrayal of the historic background of the Jewish people and the state of Israel. Then, it provides a description of the relevant aspects concerning the state of Israel and the Israeli military. Next, a related psychological background is drawn. Based on this contextual picture, the last sessions focus on the research site – NATAL, and the service - the helpline.

Historic background

'We are not makers of history. We are made by history'.

Martin Luther King, Jr.

(King Jr, 2010)

In order to understand the psychological mechanisms and reactions of the Israeli population to the security situation one must recognize the Jewish history, the Israeli history and the impact of past experiences and ethos over time.

The history of the Jewish people is full of instability, persecutions and conflicts:

The people of Israel (also called the "Jewish People") trace their origin to Abraham, who established the belief that there is only one God, the creator of the universe. Abraham, his son Yitshak (Isaac), and grandson Jacob lived in the Land of Canaan, that later came to be known as the Land of Israel. The descendants of Abraham crystallized into a nation at about 1300 BCE (Lissak, 2009).

The names Land of Israel and Children of Israel have historically been used to refer to the biblical Kingdom of Israel and the entire Jewish people respectively. According to the Hebrew Bible, Jacob who is the patriarch was given the name Israel after he successfully wrestled with the angel of the Lord. His twelve sons became the ancestors of the Israelites, also known as the Twelve Tribes of Israel or Children of Israel (Jewish Virtual Library, n.d 1).

The area is also known as the Holy Land, being holy for all Abrahamic religions including Judaism, Christianity, Islam and the Bahá'í Faith.

The people of modern day Israel share the same language and culture shaped by the Jewish heritage and religion passed through generations starting with the founding father Abraham.

The rule of Israelites in the land of Israel starts with the conquests of Joshua (ca. 1250 BCE). The year 587 BCE marks a turning point in the history of the region. From this year onwards, the region was ruled or controlled by a succession of superpower empires of the time in the following order: Babylonian, Persian, Greek Hellenistic, Roman and Byzantine Empires, Islamic and Christian crusaders, Ottoman Empire, and the British Empire (in the 20th century). The Jewish people were exiled several times by the different rulers of the country and were forced to migrate to Europe and North Africa (Reich & Goldberg, 2008).

In the year 70 CE, the Romans suppressed the Jewish Revolt, captured Jerusalem and destroyed the Temple. Suppression of the Bar-Kochva Revolt in 135 CE permanently ended Jewish sovereignty in their land, and they had to leave their homeland where their ancestors lived, although Jewish presence in the land never entirely ceased. The Jews went into an exile that lasted two thousand years, during which they experienced discrimination, persecution and expulsion. During that entire period, the Jews held on to their dream to return to their homeland and kept their religion, language, and customs alive in an unparalleled act of collective memory. Less a race or a tribe than what Giulio Meotti calls a "metaphysical family" (Meotti, 2010).

In the first half of the 20th century there were major waves of immigration of Jews back to Israel from Arab countries and from Europe. During the British rule in Palestine, the Jewish people were subject to great violence and massacres directed by Arab civilians or forces of the neighboring Arab states (Lissak, 2009).

<u>The Holocaust</u>

During the Second World War, the Nazi regime in Germany developed the plan to annihilate the Jews of Europe - this was to be the "final solution". The Nazi regime decimated about 6 million Jews creating the great tragedy of The Holocaust. The extermination was carried out by the Germans, but elements from among other peoples helped. Moreover, the Allies did nothing to stop it (Reich & Goldberg, 2008).

The Holocaust is not only genocide, one among many. It is unique because the Holocaust was the extermination of a civilization and the attempt to utterly annihilate another people who its perpetrators first condemned and dehumanized – and that has no parallel and no precedent (Jewish Virtual Library, n.d 3).

Before the Holocaust, there were some 16.6 million Jews across the world. After the Nazis' mass extermination, in 1945, only around 11 million Jews remained. Today, seventy years after the Holocaust, the number of Jews worldwide is finally close to returning to what it was before World War II – according to a report issued by the Jewish People Policy Institute (JPPI), since the end of

the war in 1945, the number of Jews in the world consistently increased, reaching some 14.2 million in early 2015 (Eichner, 2015).

Gradually this historic event changed from a traumatic constitutive myth into shaping national consciousness: The Holocaust was conceptualized as a national tragedy of the Jewish People, and thus became a basic component of post-modern Jewish identity (Meotti, 2010).

The Holocaust is not only an event of historic and symbolic meaning but also a greatly influential factor in the current political reality. The link between the Jewish Holocaust and the creation of the State of Israel was and still is inseparable: With the end of World War II Jews from all over Europe began to attempt to reach Israel (which was still not a state) in order to join their people and members of their families. Survivors of the concentration camps tried to get to Israel, but the British regime then in power refused to allow survivors to enter the Land of Israel. With the assistance of the Zionist communities in Israel European Jews set out for Israel taking ships covertly and illegally. The British captured a large number of the boats and transferred their Jewish passengers to detention camps in Cyprus. That led several countries to begin to raise international pressure to allow the Jewish People to create a state in Israel (Reich & Goldberg, 2008).

"The re-borne state of Israel is this fundamental act of life and meaning of the Jewish people after Auschwitz…" (Jaffee, 1991).

The Israeli concept is that without a state and with the power to protect them, the Jews will always be doomed to destruction and annihilation as happened in the Holocaust (Meotti, 2010).

On November 29th, 1947 the General Assembly of the UN accepted the partition plan and proposed to divide the land of Israel (called Palestine at that time) between the Jewish and the Arab inhabitants (Jewish Virtual Library, n.d 1).

Following the announcement of the Partition Plan, in 1948, the Jewish Community in Israel reestablished sovereignty over the ancient homeland and the declaration of independence of the modern State of Israel was announced on the day that the last British forces left Israel (May 14, 1948) (Lissak, 2009).

The Partition Plan was rejected by all the Arab countries. Arab leadership in Israel and in the countries surrounding Israel planned a Jihad, holy war, against Israel and encouraged the Arabs to leave Israel promising their return after they purge the land of Jews. A day after the declaration of independence of the State of Israel, armies of five Arab countries invaded Israel and marked the beginning of the War of Independence (Lissak, 2009). This combined invasion by trained professional military coalition of Arab states forced the newly born state of Israel, which had no military force at the time to fight for its survival.

The war was fought along the entire, long border of the country: against Lebanon and Syria in the north; Iraq and Transjordan (renamed Jordan during the war) in the east; Egypt, assisted by contingents from the Sudan - in the south; and Palestinians and volunteers from Arab countries in the interior of the country (Jewish Virtual Library, n.d 1).

It was the bloodiest of Israel's wars. It cost 6,373 killed in action - almost 1% of the Jewish community in Israel. At the time, the Jewish community in Israel numbered 650,000 inhabitants while the Arab inhabitants were 1.2 million (Israel Ministry of Foreign Affairs, n.d 1).

In the years following the establishment of the state, daily confrontations between Jews and Arabs continued, expressed in reciprocal hostile actions (Jewish Virtual Library, n.d 1).

In 1956, after the decision of the Egyptian government to close the Suez Canal to Israeli shipping, war broke out between Israel and Egypt (the "Sinai Campaign").

In 1967, tensions between Israel and the neighboring Arab countries intensified and Israel launched a preventive war that became known as the Six-Day War. During the war, it captured the Sinai Peninsula, the Golan Heights, the Gaza Strip and the West Bank. Violent confrontation and armed hostilities continued until 1970 in an attempt to wear down the Israeli position through long-term pressure – this is known as the War of Attrition (Israel Ministry of Foreign Affairs, n.d 1).

In the early 70s, the Arab terror organizations launched a wave of terror against Israel and Jewish targets overseas, mainly in Europe (including the Lod Airport massacre, the Entebbe Hostage Taking and the Munich massacre - an attack during the 1972 Summer Olympics in Munich, at which eleven Israeli Olympic team members were taken hostage and eventually killed) (Jewish Virtual Library, n.d 1).

On Yom Kippur, the Day of Atonement (the holiest day in the Jewish calendar when the whole country comes to a standstill while observant Jews complete twenty-five hours of total fasting and prayer), in October 1973 the armies of Egypt and Syria attacked Israel by surprise with the goal of restoring their control over the territories they lost in the Six Day War. The Israeli Forces included 350,000 troops and were largely outnumbered by the Arab coalition which included total of 914,000–1,067,500 troops. The Israeli Forces suffered severe setbacks at the beginning of the war but recovered. This war famously cost Israel grave lose: 2,521–2,800 dead, 7,250–8,800 wounded and 293 captured. The combination of the surprise attack and the high casualty rate caused bitter feelings among the public, and to this day, it is considered one of the most difficult wars (Israel Ministry of Foreign Affairs, n.d 1).

Following the war, the terror attacks against Israel continued.

In 1979, after the Egyptian president Sadat took the unprecedented step of visiting Israel, becoming the first Arab leader to do so (implicitly recognize Israel), Israel and Egypt signed the historic Israel-

Egypt Peace Treaty. Israel subsequently withdrew its troops from Sinai, in exchange for normal relations with Egypt and a lasting peace (Jewish Virtual Library, n.d 1).

In 1982, tension along Israel's northern border increased following numerous hostile violent acts on the border with Lebanon and the lobbing of rockets at Israeli localities by terror organizations. During that period there were 270 terrorist attacks by the PLO in Israel, the occupied territories, and the Jordanian and Lebanese border, in addition to 20 attacks on Israeli interests abroad. In the aftermath of a terrorist attempt to assassinate the Israeli ambassador in London, the Lebanon War broke out. Israel's goal was to protect its towns and villages along the northern border from terror attacks. Between 1982 and 2000 the IDF controlled parts of South Lebanon, engaging in numerous military confrontations leading to many Israeli killed and wounded soldiers during this period: between 1982 and 1985, the Israel Defense Forces suffered 657 dead and 3,887 wounded. From the withdrawal to the South Lebanon Security Zone in 1985 to the pullout to the international border in 2000, the IDF lost another 559 soldiers, including 256 from combat. Israeli civilian casualties from cross-border shelling numbered at 10 killed and at least 248 wounded (Israel Ministry of Foreign Affairs, n.d 1; Jewish Virtual Library, n.d 4).

In December 1987, an uprising (*Intifada*) broke out in the Territories transformed into an ongoing terror activity, until 1991 when the Madrid Accords were signed. During that period many Palestinians were injured and killed, while 179 Israeli civilians and 60 IDF personnel were killed, and more than 1,400 Israeli civilians and 1,700 soldiers were injured (Israel Ministry of Foreign Affairs, n.d 1; Jewish Virtual Library, n.d 4).

In 1991, in the course of the First Gulf War, Iraq threatened to attack Israel with various types of weapons, including non-conventional ordnance, with the declared aim of destroying a significant part of the country. Over a period of more than 1 month Israel sustained approximately 38 Iraqi Scud missiles attackes on Israeli civilian population. In this war, for the first time the rear served as the main theater of hostilities as missiles mainly hit the greater Tel Aviv region and Haifa, causing 13 civilian deaths, 433 injured and damage to general property that consisted of 1,302 houses, 6142 apartments, 23 public buildings, 200 shops and 50 cars (Israel Ministry of Foreign Affairs, n.d 1; Jewish Virtual Library, n.d 4).

Israel's government issued gas masks to the citizens.

In 1993, after a series of secret meetings between Israeli and Palestinian negotiators hosted by Norway, Israel and the Palestinians signed the Oslo Accords with the hope of reaching a peace treaty later on (Jewish Virtual Library, n.d 1).

In 1994 with the help of U.S. President Bill Clinton, Israel and Jordan signed a peace treaty.

In 1995, in the aftermath of the peace accords, a right-wing activist assassinated Prime Minister Yitzhak Rabin, and in the subsequent elections, the right-wing led by Benjamin Netanyahu took power. This eventually ground to a halt the peace process (Jewish Virtual Library, n.d 1).

In September 2000, the Second Intifada broke out and caused a wave of riots and violent demonstrations by Israeli Arabs. Following the riots, there was a high degree of tension between Jewish and Arab citizens and distrust between the Arab citizens and police. Between that time and 2005, Israel suffered many terror attacks on busses, restaurants and cafes that killed more than 1023 Israeli civilians and 5238 were injured (Israel Ministry of Foreign Affairs, n.d 1; Jewish Virtual Library, n.d 4).

In 2005, Prime Minister Ariel Sharon decided on a unilateral plan to be carried out without an agreement, whose goal was to eliminate foci of friction between Jews and Arabs by evacuating the settlements of Gush Katif [in the Gaza Strip] and of Northern Samaria. A segment of the population saw this as the expulsion of Jews from their homes and responded with fierce resistance. Despite the opposition, and the transfer of control to the Palestinians, terror from Gaza intensified and continued to this day (Jewish Virtual Library, n.d 1).

In 2006, following a terror attack from Gaza, which killed two soldiers while kidnapping another one, Israel launched an operation in Gaza. In that same year, Hezbollah kidnapped two soldiers on the northern border. The kidnapping developed into a war known as the Second Lebanon War, in the course of which northern Israel was struck by over 3970 missiles, resulting in 41 civilian and 119 military deaths (Israel Ministry of Foreign Affairs, n.d 2; Jewish Virtual Library, n.d 4). Attacks brought life to a standstill, and people began to lose faith that the Israeli Defense Forces could protect the nation (Gambill, 2006). Disruption to life was extreme; over 300,000 Israelis were evacuated, and over 1 million others lived in air-raid shelters during the month-long conflict (Israel Ministry of Foreign Affairs, n.d 2).

In 2008, following massive repeated shelling of civilian communities in southern Israel with Qassam rockets and mortar shells from the Gaza Strip, the State of Israel launched Operation Cast Lead (Jewish Virtual Library, n.d 1).

During 2009-2012, hostile actions continued against Israel, mainly missile fire against villages in the South. In 2012, following heightened missile fire, Israel launched Operation Pillar of Defense in the course of which Hamas fired missiles into the center of Israel and Jerusalem (Jewish Virtual Library, n.d 1).

In 2014, following massive missile fire toward Israel, Operation Protective Edge began. In the course of it, Hamas and its allies fired more than 4000 missiles toward the center of Israel and Jerusalem. Also, Israel had to deal with terror tunnels excavated from Gaza into Israeli territory that facilitated terrorist penetration into Israeli villages (Israel Ministry of Foreign Affairs, n.d 1).

In 2015-2016, Palestinians launched a wave of terror based on stabbings and using automobiles to run down victims. This gained the name “Intifada of the Knives” and remains ongoing.

The above account of the major events in the history of the state of Israel is only a summary of events. Although it doesn’t include thousands of terrorist attacks and missiles' fire that happen on a daily basis in Israel, it can provide a general notion of the uniquely complicated and problematic security situation in Israel.

The Arab- Israeli conflict

To sum up, the Arab- Israeli conflict began as a conflict between Jews and Arabs who lived in Palestine under the British Mandate, and it developed into a sharp inter-state conflict between newly created Israel and the Arab states during the War of Independence (Benvenisti, 2000).

The Arab- Israeli conflict focuses on a single territory that two national movements claimed as their homeland. However, the Arab- Israeli conflict is not just territorial and political since it combines additional rival religious and cultural interests (Reich & Goldberg, 2008).

This conflict was one of the prominent uncontrolled conflicts of the Twentieth Century and continues into the Twenty-First.

From 1948 to this day the Arab nations initiated several wars against Israel. The continuous Arab-Israeli conflict inflicts a life of wars and terror attacks upon the civilian population in Israel. In some areas of the country, children are living under constant fire (missile attacks) from the day they are born (Benvenisti, 2000).

To this day the Arab world and Israel are conflicted with each other over many issues. Many Arab states which don’t border Israel maintain an ongoing indirect conflict or proxy war with Israel. One of the states that Israel considers as a major threat to its security is Iran which supports and supply weapons to Hamas in Gaza, Hezbollah in Lebanon and Syria. Israel aims to prevent the Iranian government from developing and using nuclear weapons against the Israeli population.

The Arab- Israeli conflict never drops off the public agenda of the involved groups since its incidents take place almost every day and dealing with it has become a way of life.

The state of Israel and the Israeli military

'We make war that we may live in peace'.

Aristotle

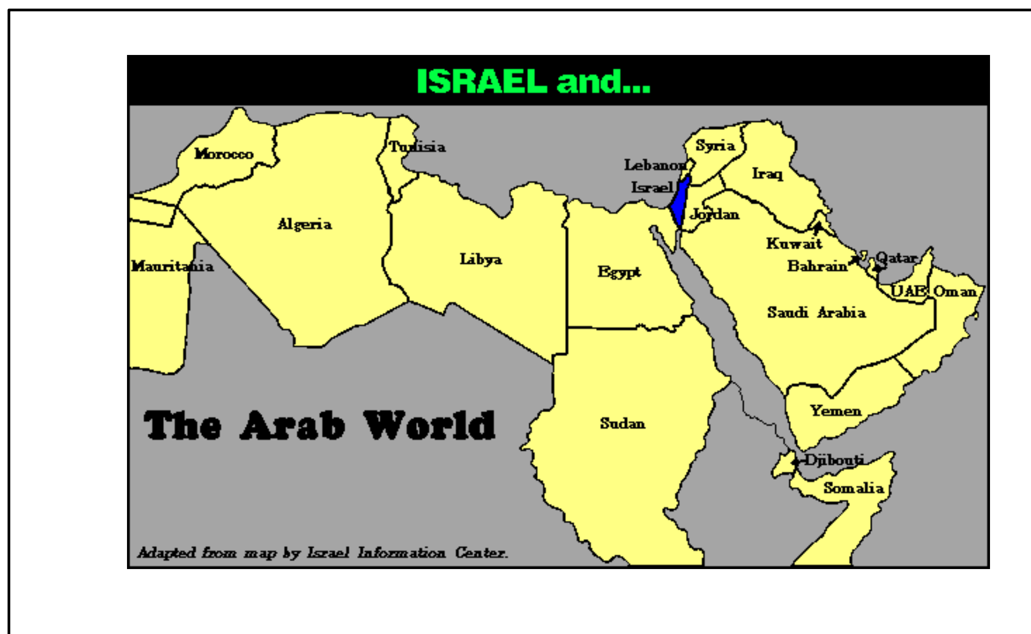
(Barnes, 2014)

Israel is the only post–World War II democracy in the world that has been in a state of constant war with its neighbors throughout the entirety of its existence.

According to the Pew Research Center in 2015 there were 50 Muslim-majority countries and over 1.7 billion Muslims in the world. 91.2% of the people living in the Middle East-North Africa are Muslims (Lipka, 2015).

Israel is surrounded by Arab countries – it shares land borders with Lebanon to the north, Syria in the northeast, Jordan on the east, the Palestinian territories comprising the West Bank and Gaza Strip to the east and west, respectively, and Egypt to the southwest (Jewish Virtual Library, n.d 2).

Figure 1 – Map of Israel and the Arab countries surrounding it



Israel is a small, narrow country. The territory of Israel is approximately 27,799 square kilometers.

Since the end of World War II Israeli society went through more wars than any other state. Moreover, even during the periods between the wars there were unending hostile acts, including terror attacks and reprisals. All of these caused the issue of national security to become a central issue in Israeli society (Bar-Tal, 2007).

The problem of how to protect the lives of individual Jews and the collective existence of the Jews of Israel is a fundamental dilemma with which the Jews in the Land of Israel have dealt for over a century (Lissak, 2009).

In light of the new strategic and geopolitical situation created after the 1948 War, Israel based its unwritten national security doctrine on the evaluation that the Arabs had not come to terms with the existence of the State of Israel and that it would not be possible to arrive at a peace agreement under conditions that, in Israel's eyes, were crucial to her survival. Therefore Israel must prepare for the 'next round'. One of Israel's senior statesmen defined Israel's situation since its creation as 'dormant war' that awakens every few years and becomes active war (Bar-Tal, 2007).

Since Israel arose through war that ended with a ceasefire that did not bring peace, therefore, from its earliest days it had to organize conceptually and institutionally to withstand a violent and ongoing conflict.

Ben-Gurion, the first prime minister of Israel shaped the concept of security of Israel based on the following suppositions: 1) the conflict is ongoing and Israel is in a situation of dormant conflict; 2) The goal of the Arabs is the destruction of Israel, so the conflict is existential; 3) The Israeli-Arab conflict is no less a danger than the Holocaust; 4) The problem of security is the most significant problem in Israel, surpassing any other challenge in its importance; 5) Ongoing danger requires the building of a "nation in uniform," necessitating broad civilian participation in the protection of the homeland (Kimmerling, 2001).

Israel's military machine is among the largest in the world relative to its population: 600,000 men and women serve in three branches—including the reserves, almost 10 percent of the population. Israel's defense budget per capita is the highest among the democracies, and among the largest p.c. in the world. Israel allocates huge resources for security needs: between a quarter and a third of her GDP, about a fifth of the resources available to the economy (including capital imports), about half of the government budget and about a quarter of the labor force (Peri, 2002).

The Israeli military was created in 1948 with an obsession for being connected with the people. The frequency of wars and the need to mobilize the young on behalf of the collective forced the State of Israel from its earliest days to construct a "myth of participation in war", which is to say, the society had to find ways in a systematic and directed fashion, to strengthen recognition of the exalted nature of military service and war (Meotti, 2010).

The Israeli military is at the heart of the Jewish State. There is compulsory military service of three years for men, two years for women, and reserve duties lasting to the age of fifty. The military service is an unconditional, mandatory national duty. This compulsory military service, beginning at the age of eighteen means that everyone must defend the country - every child becomes a soldier, and the entire country is a front (Ben-Ari & Lomsky-Feder, 2011, Meotti, 2010). It is important to emphasize that although the military service is compulsory there is a very high motivation of Jewish Israelis to join the military – most of the Israeli soldiers would have enlisted even if this was not compulsory. Most Israelis (due to social norms) feel it is a privilege and their responsibility to defend their families, homes and country.

A good part of the armed forces of the industrial democracies is comprised of reservists, troops standing outside the regular force but being mobilized for routine assignments or activated in times of crisis. Although considerably downsized, reservists still comprise the bulk of Israel's military whose use is aimed at solving the manpower problems of a relatively small population facing a situation of protracted conflict along its borders. In Hebrew they are called *"miluim*", and they are a symbol of Israeli self-sacrifice. They are army reservists, between the age of 25 and 50. It is the 400,000 "old guys" ready to rush off in times of danger to wherever their country needs them, even at the risk of their business interests, who enable the Jewish nation to mobilize for every war (Ben-Ari & Lomsky-Feder, 2011, Meotti, 2010).

The IDF (Israel Defense Force) is a citizens' army. It reflects the mosaic of which civil society is composed (Peri, 2002). The military culture and mentality invaded and absorbed such a large part of Israeli civil culture that it is almost impossible to differentiate between them.

The Jewish-Israeli society is 'a society in uniform'. The existence of such paradigm requires broad national agreement about the existence of a grave external threat to the state that justifies allocation of large amounts of resources to security needs, and engagement of the military sector in political processes of decision making. That forms a template of military-society relations that includes a measure of civilianization of the army on the one hand and militarization of the civilian sector on the other (Kimmerling, 2001).

Preparation for military service was and is an inseparable part of Israeli education. Military service is part of the normative course of the life of the youth in Israel, and society sees service in combat and elite units as highly honorable. Most Jewish-Israeli young men and women serve in compulsory military service, see it as an important part of life in the State of Israel and understand it as one of their formative experiences. The IDF is still the institution with the highest levels of public faith in the country (between 85-92%) and rates higher than the Supreme Court, the police, the prime minister, etc. (Bar-Tal, 2007).

Ramifications of this compulsory military service for the lives of individuals include: A) delay of entry into the labor force or delay in gaining higher education and professional skills. B) A man in reserve

service needs permission from his military unit to travel outside the country; he must always be available (Kimmerling, 2001).

Israel, while engaged in a longstanding violent conflict, does not act like a society under siege. Israel has not become a Spartan 'barracks country' ruled by 'experts at violence,' all of whose lifestyle is dedicated to the need to respond to the challenges of the external threat. It is closer to the model of Athens, who, despite her wars maintained democracy and a 'civilian' lifestyle in times of calm.

The State of Israel has some 8.46 million inhabitants. The most prominent characteristic of Israel's population is its high diversity. Since its establishment, some 2.7 million Jews have immigrated to Israel from 130 countries - from survivors of the Holocaust to Soviet and Ethiopian Jews, the State of Israel never ceased to be a land of immigration: 9 out of 10 Jewish Israelis today are immigrants or descendants of immigrants the first or second generation (Jewish Virtual Library, n.d 2).

Due to its immigrant nature, Israel is one of the most multicultural and multilingual societies in the world - The number of individual languages listed for Israel is 35 (Ethnologue, 2015).

Israel is a developed country and an OECD member, with the 37th-largest economy in the world by nominal gross domestic product as of 2014.

The country has the highest standard of living in the Middle East and the fourth highest in Asia, and has one of the highest life expectancies in the world (Jewish Virtual Library, n.d 4).

Israel exhibits the paradox of life and death - despite the daily security problems the population tries to maintain a lively and rich routine: a vibrant music and art scene reflects Israel's diverse culture. The city of Tel Aviv is characterized by its nightclubs featuring internationally renowned DJs and its around-the-clock cafés - it has earned its nickname, "the city that never stops."

Today, Israel has more museums per capita than any other country in the world and one of the highest theater-going rates in the world. Israel has produced six Nobel Prize-winning scientists since 2002 and has been frequently ranked as one of the countries with the highest ratios of scientific papers per capita in the world (Jewish Virtual Library, n.d 2).

Education in Israel is highly valued in the national culture with its historical values dating back to Ancient Israel. With contemporary Jewish culture's strong emphasis, promotion of scholarship and learning and the strong propensity to promote cultivation of intellectual pursuits as well as the nation's high university educational attainment rate exemplifies how highly Israeli society values higher education. The country benefits from a highly skilled workforce and is among the most educated countries in the world with the one of the highest percentage of its citizens holding a tertiary education degree (in 2012, the country ranked second among OECD countries, tied with Japan and after Canada, for the percentage of 25- to 64-year-olds that have attained tertiary education with 46 percent compared with the OECD average of 32 percent). In addition, nearly twice as many Israelis

aged 55–64 held a higher education degree compared to other OECD countries, with 47 percent holding an academic degree compared with the OECD average of 25% (Jewish Virtual Library, n.d 4).

Its highly motivated and educated populace is largely responsible for spurring the country's high technology boom and rapid economic development: According to the OECD, Israel is ranked 1st in the world in expenditure on Research and Development (R&D) as a percentage of GDP. Intel and Microsoft built their first overseas research and development centers in Israel, and other high-tech multi-national corporations, such as IBM, Google, Apple, HP, Cisco Systems, and Motorola, have opened R&D facilities in the country (Jewish Virtual Library, n.d 4).

The book "Start-up Nation: The Story of Israel's Economic Miracle" was published in 2009 by Dan Senor and Saul Singer and describes how Israel—a country of 7.1 million people, only sixty years old, surrounded by enemies, in a constant state of war since its founding, with no natural resources—produces more start-up companies than large, peaceful, and stable nations like Japan, China, India, Korea, Canada, and the United Kingdom. Israel was able to reach such economic growth that at the start of 2009, some 63 Israeli companies were listed on the NASDAQ (125 companies today), more than those of any other foreign country. Israel now has more high-tech start-ups and a larger venture capital industry per capita than any other country in the world (Senor & Singer, 2009).

Life in Israel, with its mission and commitment to defend and maintain the Jewish people and tradition, and with its daily struggles for survival, may provide individuals with a sense of value, a dedication to a goal, and an awareness of a worthwhile life (Lieblich, 1983).

The Israelis have shown that they love life more than they fear death. Every time a bomb explodes, the signs of the blast are quickly removed; windows are repaired; bullet holes are patched. The places that were blown up reopen after two days. Life has always won over death (Meotti, 2010). Moreover, it seems that the close presence of death in everyday life may also have a positive effect which promotes clinginess to life and an attitude of "carpe diem".

Psychological background

'In Israel, in order to be a realist you must believe in miracles'.

***David Ben-Gurion** - first Prime Minister of Israel*

(Ben-Gurion & Nurock, 1954)

Israel is the first country ever to experience suicide terrorism on a mass scale (Meotti, 2010). Israelis see the power of the regular Arab armies as a danger to the very existence of the State of Israel (‘politicide’) while terror activities are seen as a danger to the lives of the citizens and not to the sovereignty of the state and its functioning (Bar-Tal, 2007).

In the Israeli case, there is a sub conventional war. It is a war conducted within civilian territory, in the heart of a civilian population. It is designed not to conquer territories or to destroy enemy formations, but first and foremost to break the enemy’s will to continue with its resistance, to conquer the heart of the insurgent population, and to win the battle of domestic and international public opinion (Peri, 2002).

In such a society in an ongoing conflict, the subjects of personal and collective security defense become a central public and private subject of discussion - not only of conversation, but rather of the tangible influences on the life of the individual (reserve service, fatalities, disabilities, etc.).

According to Bar-Tal (2007), these beliefs hold a central position in the thinking of most of the Jewish public:

1. The 6.5 million Jews who live in Israel are surrounded by 317,070,000 Muslims living in the Middle East-North Africa and therefore there is permanent crucial danger.

   The Jewish public in Israel carries a concept of ongoing threat accompanied by the belief that a second Holocaust could happen in our day. They believe that they face a real threat to the security of Israel as a state and its Jewish citizens and that the threat is existential.

2. The Jewish-Arab conflict is usually understood as unalterable and uncontrollable, a kind of “eternal” fate or type of Greek tragedy in which the two peoples are doomed to play.

3. The Jewish Israelis see the security problems of Israel as unique, extraordinary, and not similar to the defense problems of any other state. They see them as more serious because of the hostile environment, the broad support of the Arabs by the Islamic countries, the high

level of violence of the conflict, the extremism that feeds this violence and the setting up of the Jews and the State of Israel as targets because of their belonging to Western culture.

4. Another belief is that Israel must depend only on her own strength. It should not expect assistance from other states and peoples and should not depend on them (this belief derives from the siege mentality based in large measure on the lessons of the Holocaust).

Living in Israel means living in constant fear: of being hurt or killed by a terrorist/bomb/missile, of losing one of your loved ones due to terror or war, of not being able to relax and trust other citizens around you (because they might be Arabs and want to hurt you), of feeling misunderstood, judged and persecutes by other nations worldwide. It is a life of constant struggle, stress, insecurity and sometimes helplessness and despair. On the other hand, the Israeli ethos is of toughness and strength, determination and survival against all odds.

In searching for a meaningful theoretical frame of reference for understanding the effects of the ongoing stress of living-with-war on Israelis, one may find a reflection of the duality presented (and lived) by Israelis: on the one hand Laing's (1960) general approach is that living constantly with the threat of war may produce the psychological condition of basic insecurity. On the other hand, from Frankl's (1984) point of view, it may facilitate the development of a sense of mission and meaning to one's individual existence.

Strength and aggressiveness are results of complete Jewish helplessness during the Holocaust, and they conceptualize these as a necessity in the reality of violent Israeli-Arab conflict. In this way, through a circular process, the memory of the Holocaust charges and gives meaning to the Israeli-Arab conflict while the discourse on the conflict strengthens the role of the Holocaust as a founding myth of Israel (Zertal, 2002).

People who meet Israelis for the first time often comment on the tough front they are presenting to the world around them. This impression has become an integral part of the Israeli stereotype. The apparent toughness of Israelis and of Israeli men in particular, results from the excessive social stress on the need for heroism, which is, in turn, produced by multifaceted processes of various historical origins, such as the trauma of the Holocaust, and the continuous political and military tension in the Middle East (Lieblich, 1983).

Undoubtedly, the memory of the Holocaust, even if not experienced directly, has a profound effect on the emotional life in Israel. Being "different than the Holocaust generation" means to be strong, the oppressor rather than the oppressed. This seems to be a sure way to prevent another holocaust from occurring. In addition to that since the Jewish existence in Israel has always been a threatened

by the Arabs, the focus on strength in the Israeli identity has been sheer need for survival. Strength is of tremendous importance to Israelis and their identity as individuals. The need for power is so central that any signs of weakness are regarded as threats to the identity-as-a-whole and are, therefore, concealed from view (Zertal, 2002).

Reality and psychology swing back and forth between two extreme experiences: destruction and redemption, death and rebirth, helplessness and strength.

The most direct cause for the tough, strong aspect of the Israeli personality is, naturally, fear of death and injury, the basic need for survival under threatening conditions. These conditions make strength a very necessary ingredient for the continuous life in Israel (Lieblich, 1983).

The Israeli norm is to respect independence, achievement, and performance above words and feelings, but also the sacred value that gives priority to the state, the nation, its security and its future, rather than to the individual and his private need and aspiration (Kimmerling, 2001).

The pressure toward heroism is transmitted both on overt and covert levels. Strength is both physical and spiritual. The ideal is also understood to demand the denial of emotionality and sensitivity, the development of a tough, harsh facade, and scorn for weakness of any sort (Lieblich, 1983).

Naturally, the message of heroism is transmitted primarily to men in Israel. They are the soldiers who fight the wars, they serve more often in the military reserves, and thus they are trained and retrained to play faithfully the heroic role. The price Israeli men are paying for this internalized social role, in terms of the denial of emotional life, is also much higher. Women, however, do not completely escape this influence. They are shaped to be stronger than women elsewhere in the sense of readiness to support – and sometimes sacrifice – the men around them in their military role (Lieblich, 1983).

This duality between strength and weakness, concession versus survival and emotional expression as opposed to repression creates internal conflict between individual emotional responses and societal norms and expectations (Zertal, 2002).

This work does not aspire to determine whether Israeli men and women are indeed tougher and more resilient due to the circumstances of their past history and current challenges or they are just displaying a façade adhering to societal norms. Yet it is important to acknowledge the existence of such a conflict between individual emotional responses and societal expectations – an internal conflict that has a paramount influence on help-seeking behavior of Israelis.

Seeking help is often an emotionally costly exercise for an individual and is often a second choice for people. People will predominantly want to seek help by themselves, for themselves without any social implications (Campos, 2009).

Help-seeking is not an easy task for the individual at any culture, yet alone in a society that dictates toughness and self-reliance. Moreover, seeking help regarding the effect of the military role is in contrast with the message of heroism expected from men and women. Indeed the founders of Natal believed that there is a need for such an organization in order to raise public awareness to trauma related to terror and war and in order to provide better accessibility to mental health services to those who suffer but are reluctant to ask for help.

NATAL

'How wonderful it is that nobody need wait a single moment before starting to improve the world'.

Anne Frank

(Frank, 1999)

NATAL was officially established in the middle of 1998 but the process of establishment began more than a year before that.

Life in Israel is never quiet or serine but in 1997, the year we started to work as a think-team, it was neither quiet nor turbulent: three years before that, following the Oslo agreements and the peace treaty with Jordan, the public atmosphere was cautiously optimistic, but then came the murder of prime minister Rabin and the country was preoccupied with its aftermath, directing the focus of attention towards inner conflict rather than external threats. It was a time of reflection and heightened awareness of the heavy toll of the security situation. There was a heated public debate regarding the likelihood of ending the Israel-Arab conflict. It involved bereaved families, veterans and ex-generals who presented opposite views, beliefs and predictions. This public debate reflected the inner struggle between optimism, hope, yearning for peace of mind and suspicion, mistrust and insecurity. It drew attention to the emotional wounds we carry as a people and as a nation.

It is only natural that the bereaved, the injured, their caregivers and their therapists are exceptionally involved at times like these – and I believe that this is one of the main factors that contributed to the inception of NATAL at that time.

NATAL is a realization of a life-long dream of one of the co-founder, Dr. Yossi Hadar, whose life story is a reflection of Jewish Israeli history: Yossi was born in Belgium in 1946 to parents who were Holocaust survivors. He and his family sailed for Israel but were captured by the British and sent to a transit camp in Cyprus. They immigrated to Israel on November 29, 1947. He studied medicine in the Hebrew University and joined the army in 1971 where he served as a Regional Physician. During the Yom Kippur War, Yossi, a paramedic and two other soldiers were nearly taken captive by Syrian forces but the group managed to escape at the last moment. Throughout the war Yossi saved lives as he operated on wounded soldiers under combat conditions. The Yom Kippur War left a deep impression on Yossi and he suffered from symptoms of PTSD as a result. That, compounded with the traumas his family dealt with due to the Holocaust, influenced him to study psychiatry. During Operation Peace for Galilee, he served in the reserves and headed the Airborne Medical Unit.

Yossi held the Eli Weisel Chair for Holocaust Research at Bar- Ilan University and headed the Psychotherapy program there for four years.

His personal experience, as a trauma survivor, as a second generation to Holocaust survivors and as a physician and psychiatrist helping wounded soldiers led him to develop a unique sensitivity and understanding of people suffering from trauma and PTSD. He felt that the mental health services available at that time were not up to par and dreamed of developing a better suited solution. He envisioned an organization that will provide a holistic and sensitive care for veterans and civilians affected by the Israeli-Arab conflict.

Yossi who was also a playwright, poet and author didn’t live to see his vision materialize and grow into an established institution, as he had dreamed - approximately two weeks before the official opening of NATAL in June 1998, Yossi was diagnosed with severe leukemia and passed away.

The second co-founder of NATAL is Judith Yovel Recanati. She was born in Tel- Aviv in 1951 and was an active leader in the community scouts and served as Women's Corps and Nursing Officer in the Israel Defense Forces. At the end of her military service, she began studying psychology at the Hebrew University in Jerusalem but as the result of the Yom Kippur war continued studying archaeology at Tel Aviv University. During the Yom Kippur war, she returned to military service as an officer responsible for hospitalized and injured soldiers. In her 30s, Judith began to study art therapy at Lesley College which gave her the opportunity, to work with patients suffering from head injuries and Post-Traumatic Stress Disorder. When she completed the course, she began studying psychotherapy at Bar Ilan University where she met psychiatrist Dr. Yossi Hadar, who was her thesis advisor. Later, he initiated the establishment of NATAL and Judith joined him. She has served as Chairperson of the association since its establishment and works full-time on a volunteer basis.

I have was introduced to Judith about 8 years before the establishment of NATAL in an NGO I was working with as a helpline manager and Judith was a major donor to that organization. We have met

many times during different events of that organization and had a mutual appreciation to each other's work. After the tragic loss of my best friend in a terrorist attack, as a part of coping with my grieving process, I joined the steering committee and served as a member of the think-team that created and launched NATAL.

It is a privilege to be involved in such a unique process of conception and construction: every week the think-team had a meeting in Judith's home and discussed key themes regarding the nature and operation of this future organization. We invented a name and designed a logo - NATAL is the Hebrew acronym of "victims of national trauma". The logo was first designed after the Israeli flag to represent the national trauma, but since we wanted to uphold the apolitical nature of the organization it was changed to the existing logo of a tree that was bent by adverse storms (but didn't break). This tree represents life, struggle and survival.

Figure 2 - NATAL English and Hebrew logos

We tried to find supporters and voluntary personnel. We were concerned with office space and other logistics. But mainly we helped finalize the professional vision:

Yossi envisioned a professional clinic that will develop expertise in treating national/collective trauma - this is a new term in psychology that wasn't at all known when NATAL was founded (it will be further discussed and elaborated in the next chapter). Everyone involved in the creation of the organization shared the belief that many people in Israel have experienced trauma and loss resulting from terror and war. These people pay the heavy toll of the Israel-Arab conflict and carry visible and invisible wounds. Unfortunately, there wasn't enough awareness and resources to care and provide services to all that were inflicted. We thought that it is the state's duty to take care of these people, and if the state can't provide for them then it is our responsibility. As mental health professionals we wanted to offer therapy in order to help people regain their strengths and be able to restore their lives.

The think-team started to plan the future clinic, discussing our personal and professional understandings and beliefs. We realized that:

1. Trauma and loss due to terror and war affect many people in the Israeli society.
2. Due to insufficient public awareness, there are many people suffering from direct or indirect trauma yet they aren't conscious and don't recognize neither the cause nor the solution to their problem. They don't understand what they are going through and feel no one understands them.
3. Our potential clients, suffering from trauma, might find it difficult to seek help.
4. Many of our potential clients have already sought help from the formal governmental institutions only to face bureaucracy that led them to mistrust and despair.

These realizations helped us form the basis of the service we wish to provide:

1. The service will be offered to anyone who considers themselves affected by the Israel-Arab conflict – directly and indirectly.
2. The service will aim to be accessible and not bureaucratic.
3. Services offered by the organization will be inexpensive and affordable in order to guarantee that lack of finances will not prevent people from getting the assistance they need.
4. The organization will work to raise public awareness to national trauma and by that will also assist these people to get the recognition they need and deserve.

After agreeing on the vision for the center we started working on some practical issues. We planned a public awareness campaign and thought how best to advertise our services. We strategized building connections with the formal governmental institutions responsible of providing services to our clients so that we can collaborate with them. We discussed and designed an intake process that will provide information but won't be too intrusive.

We thought about our future clients, their needs, difficulties and challenges. We aimed to best suit this organization's services to these clients.

Through all these discussions I found myself saying times and times again: "we need a helpline". My former knowledge about helplines led me to believe that in order to be more accessible to our clients we need a gateway to the organization – which can be best achieved by a helpline. All the members of think-team were clinicians who had no knowledge or experience with helplines and therefore at first my suggestion didn't receive much attention. I persevered continuously demonstrating my

conviction and passion and finally reached the ears and the hearts of my colleagues convincing them of the importance of the helpline.

The helpline

'Most people never listen'.

Ernest Hemingway

(Baker, 2003)

It was the beginning of 1998 and I got the approval of the steering committee to initiate a helpline for Natal. It was a blessing and a privilege to work on this project under the guidance of Dr. Yossi Hadar – he respected my former training and experience, appreciated my expertise and believed in my abilities (more than I can say for myself). He told me that he trusts me to construct a good helpline and that I have a "carte blanche" to design it to the best of my ability. He offered his support and advice whenever I will need it but thought I was more informed of the subject than him and therefore wanted me to take the lead.

I appreciated Yossi's attitude and was grateful for his trust, nevertheless I felt a huge responsibility towards him, the organization and our clients. I realized I was given a unique opportunity to utilize my experience and the lessons learned to create something new.

Being given a blank canvas I could try to design a different model. My experience taught me the advantages and disadvantages of the existing model and I started thinking of ways to avoid some of the difficulties I observed. At the same time it was also very important to me to hear from potential clients and get a better understanding of their needs and wishes. I spent a lot of time meeting potential clients and interviewing them – in a way I was working on a qualitative research that led to the design of the helpline.

One of the most important epiphanies I had was during a conversation with the wife of a veteran suffering from PTSD:

P.G. was about 40 years old and married her husband before the war.

Her husband was a reserve soldier who fought in one of the most brutal battles of the Yom Kipur war. Many of his friends were injured and killed. He came back home and returned to his "ordinary" life but it was not the same life he had lived before. The sights, the voices, the smells haunted him. He was restless. Every small noise made him jump. He couldn't concentrate. At night he could not fall asleep. At work, it was hard for him to function and he changed jobs. At home, relationships were strenuous and did not return to what they were. 15 years after he returned from the war he was finally diagnosed as having PTSD and started receiving medications and therapy. By that time his whole family was affected by his condition. His children were estranged from him and they had tense and distant relationship. His wife cared for him all those years but had to function as his parent more than a spouse, and had to carry the burden of raising the children by herself and facilitating their relationship. Common to many spouses, due to secondary traumatization, she began exhibiting signs and symptoms parallel those of her husband (the direct trauma survivor), although they were less intense.

During our conversation she shared with me her daily struggles. She was a strong woman who had to cope with hardship but didn't give up and cared for so many people she was almost unable to care for herself. 5 years prior to our meeting, the formal governmental institutions started providing her husband with mental health care and with a monthly financial support, which helped the family a lot, yet she and their children were not entitled to receive any mental health support.

It was clear that our decision at NATAL to provide services to all who were affected including family members who were indirectly affected was the right decision.

What were evident in the conversation were her emotional affliction and her loneliness. While she had to provide so much support to her family she didn't have a support system. She needed someone that will care for her and help her carry the load.

I described to her the services we envisioned in NATAL and asked for her feedback. When she realized I was the person behind the idea of the helpline she told me she thought it was a very good idea, and that she called a helpline many times when she had a crisis. She said it was crucial for her to get some assistance without having to leave her husband or children alone at home, therefore calling a helpline was a practical convenient solution. In fact that was the only kind of support she was able to get. I expressed my satisfaction regarding the fact she found a good resource for support and conveyed my hope we will be able to support others like her through our helpline. Then she said: "you know it is good to have some sort of an answer but it is not an ideal answer for people like me". I thought she was referring to her need for therapy and that the helpline wasn't a professional or comprehensive enough of a substitute for her. I was surprised to learn that the problem laid elsewhere: "I enjoy the convenience of the calls and appreciate having an outlet to my distress, but the conversations are exhausting and somewhat redundant. Every time I call I speak with a very nice volunteer. I can hear their good will and that they are interested in listening to my troubles. The

problem is that every time I talk with a different volunteer who doesn't know my life story and therefore every time I have to introduce myself and provide the background story so that they can understand my current problem. For example, I had a bad day because we went to the mall to buy clothes for my son but upon arrival my husband wasn't willing to enter the mall since it felt crowded and scared him. I stood there torn between my son and my husband and in the end they were both frustrated and angry with me. When we arrived home I picked up the phone and called the helpline. I needed to share the experience and my distress. I needed someone to tell me how I could have better handled the situation. I needed someone to support me and be on my side. When I called the helpline there was this lovely woman who answered and she wanted to understand me – but it is impossible to understand this incident without knowing my husband's condition, his symptoms and functional difficulties, the problematic relationships between him and my son and my expected roles in the family – I had to explain all that before I could talk about today's incident. It took me a long time to describe the situation and the context so by the time I finished it was very late, the volunteer and me needed to end the conversation and I was too tired to talk about the incident or to take some advice".

My professional education and experience in helplines focused on crisis interventions. The helpline indeed provided her with a crisis intervention, which was appropriate since it was possible to refer to the described incident as a crisis (of a small scale). However I could hear her extraordinary need that derived from her extraordinary circumstance. It required an extraordinary solution – an extraordinary service. It was an epiphany – I was confronted with a growing understanding that helpline services as I know them and as I can find them in professional literature weren't adequate for people like P.G. – I believed it was the time and an opportunity to create something new that will be more suitable for our clients.

This was the first step of a journey that took several months during which I re-read a lot of professional material in the fields of trauma and loss and also in the field of helplines and phone interventions.

The final step of the first part of this journey was assembling the theoretical information, the data I collected from interviews with potential clients, feedback from my colleagues and my personal experience combined with experiences of close family and friends – gathering all this input and synthesizing it to create a new model of phone interventions, in the hope it will prove to best suit the needs of people suffering from national trauma and loss.

Following this introductory chapter, after providing contextual, historical and psychological background, and after describing the related aspects which led to the development of NATAL and

the helpline, this should be also connected to a theoretical background. The next part presents a literature review, starting with a chapter concerning trauma and loss.

PART III

Literature Review

Chapter 4

Trauma and Loss

In structuring the format of this chapter a few theoretical definitions need to be offered, and links need to be made. First, the concept of trauma is discussed, including a definition and diagnosis of Post-traumatic stress disorder; second, loss and bereavement are described; and third, an account of trauma and loss treatment is provided, presenting the main therapeutic theories and practices of this field. Lastly, an attempt is made to describe and define the concept of 'national trauma', followed by its link to the Israeli situation.

Trauma

'Out of suffering have emerged the strongest souls'.

Kahlil Gibran

(Gibran, 2013)

The word trauma, derived from the Greek language, literally means "injury". Many scholars suggested different definitions of trauma. Common to most of them is that psychological trauma occurs as a result of a person's exposure to catastrophic life events which bring severe threat to their lives or as a result of violent or sudden death of a close one (Seligman & Rosenhan, 1998; Davenson, 2004; Weathers & Keane, 2008; Keinan, 2012).

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition, (American Psychiatric Association, 2013) specifically defines a trauma as an event in which an individual person is exposed to actual or threatened death, serious injury, or sexual violence where the person is directly experiencing the traumatic event. Also, witnessing, in person the event as it occurred to others; or learning that the traumatic event occurred to a close family member or close friend (in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental). Also, a person who experience repeated or extreme exposure to aversive details of a traumatic event (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse). The last criterion does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related (p. 271).

However, research literature has demonstrated that only a minority of trauma-exposed individuals develop PTSD or other trauma-related disorders.

Post-traumatic Stress Disorder (PTSD) is a psychological disorder that might develop after an exposure to a traumatic event. The PTSD diagnostic criteria according to the American Psychiatric Association, DSM-5, 2013, requires an exposure to actual or threatened death or serious injury, by directly experiencing the traumatic event(s), or witnessing the event(s) as it occurred to others, or learning that the event(s) occurred to a close family member/close friend, or experiencing repeated or extreme exposure to aversive details of the traumatic event (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).

The second diagnostic criterion for PTSD is the presence of one (or more) of intrusion symptoms associated with the traumatic event, beginning after the traumatic event occurred, such as recurrent, involuntary, and intrusive distressing memories of the traumatic event, or recurrent distressing dreams in which the content and/or effect of the dream are related to the event, or having dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event is recurring, or having intense or prolonged psychological distress or marked psychological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event, or persistently avoiding stimuli associated with the traumatic event, beginning after the traumatic event occurred.

Another criterion for PTSD diagnosis is avoidance of or efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event, or avoidance of external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts or feelings.

Negative alterations in cognitions and mood associated with the traumatic event, beginning or worsening after the traumatic event occurred is another diagnostic criterion. Also, marked alternations in arousal and reactivity associated with the traumatic event, beginning or worsening after the traumatic event occurred (e.g. Irritable behavior and angry outbursts, reckless or self-destructive behavior, hypervigilance, exaggerated startle response, problems with concentration or sleep disturbance).

The PTSD diagnostic criteria requires that the duration of the disturbance is more than 1 month, and that the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Traumatic events might result in physical trauma, psychological trauma, or both.

Psychological trauma is the unique individual experience of an event, in which the individual's ability to integrate his/her emotional experience is overwhelmed or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity (Pearlman & Saakvitne, 1995). The suddenness of an event is an essential part of what makes an experience traumatic. When the amount of time between the person's awareness of a negative, uncontrollable event is very brief, there is not enough time for the person to act to either physically protect himself from harm or to psychologically prepare for a negative outcome (Reyes, Elhai & Ford, 2008). Moreover, Sar and Ozturk (2006) assert that in a traumatic situation, an adequate response is not possible despite the existential threat. This inherent paradox drives the trauma process.

There are many possible psychological and behavioral consequences of traumatic events, including generalized distress, intrusive ruminations, physical symptoms, increased health care utilization, disruptions in functioning, decreased subjective well-being, meaning-making, construal of personal benefits, and positive community effects (Silver et al., 2005).

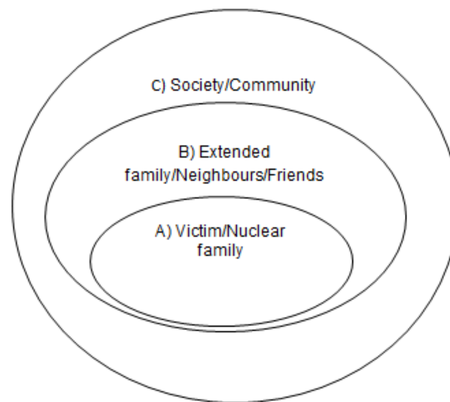
Herman (1994) noticed that traumatic events tear apart familial, friendly, romantic and community ties.

Similarly, Neimeyer, Burke, Mackay, & van Dyke Stringer (2010) suggest that some people find that their own resources and those of their social world are insufficient to help them accommodate the gravity of the loss/trauma. Also, Sar and Ozturk (2006) maintain that PTSD is associated with high levels of social, occupational and physical disability, as well as considerable economic costs and high level of medical utilization. Impaired functioning is exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains. In community and veteran samples, PTSD is associated with poor social and family relationships, absenteeism from work, lower income, and lower educational and occupational success.

It is evident then, that trauma has a devastating effect not only on the direct victim but also on large populations that surround the victim – from close family members, through the community to the entire society.

Tamir and Haimov (2005) describe the vast effect of the trauma as follows: Like a pebble thrown into water, loss and trauma as a result of war or terror events create concentric circles of victims (see figure 3).

Figure 3 - Circles of Victims



The inner-most circle (A) includes the victims themselves and their nuclear family: spouses, parents, children, and siblings.

Family members, especially spouses may suffer from PTSD symptoms similar to the trauma victim – what is known as "secondary traumatization" (Monson, Taft, & Fredman, 2009). Secondary traumatization is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Family members of trauma victims are often exposed to the traumatic experience and symptoms of the victim, and therefore sometimes suffer secondary traumatization. Its symptoms mimic those of post-traumatic stress disorder (e.g detachment, avoidance and difficulties with anger management), and have severe impact on spousal relations resulting with substantial impairment (Friedman-Peleg, 2014, Dekel, Goldblatt, Keidar, Solomon, & Polliack 2005).

The second circle (B) includes relatives of the wounded - the extended family, neighbors, and friends. These people also cope with the trauma/loss, while at the same time they carry the burden of caring for and treating their injured relatives. They feel helplessness and lack of knowledge and skill to care for their loved ones who were hurt. However, according to the Israeli law, they are not entitled to assistance or recognition from official institutions (Tamir & Haimov, 2005).

The outermost circle (C) includes people who were neither present at the event nor were they acquaintances of the victims, but rather were exposed to the event through the media. Inside this circle we find many citizens of the state who may experience a lack of security in routine life. These include parents of combat soldiers in the military, parents questioning their ability to provide their children with a ‘normal life’, as well as family members who worry about one another due to riding on the bus, or shopping in a mall for example (Tamir & Haimov, 2005).

As described above, large populations are affected by trauma, yet the majority of people who have undergone even the most dreadful experiences do not subsequently develop a chronic mental disorder. Brunner (2002) claims that a large prevalence study, which surveyed almost 6000 respondents, found that less than 10% of men and about 20% of women who were exposed to a trauma developed a traumatic disorder.

Other researchers estimated that about ten percent of women and five percent of men will develop post-traumatic stress disorder following adversity, and another fifteen percent of the population will suffer post-traumatic symptoms without having the disorder (Kessler, 2000; Johnson, Maxwell, & Galea, 2009; Gil et al., 2016; Greene, Neria & Gross, 2016).

The connection between trauma and loss can be found in many researches maintaining that one of the stressors that have been found to correlate with subsequent PTSD in civilian populations include the violent death of loved ones (Breslau & Kessler 2001; Carelton, Peluso, Collimore, & Asmundson, 2011; Gold, Marx, Soler-Baillo, & Sloan, 2005; Kilpatrick et al., 1998; Long et al., 2008; Prigerson et al., 2009; Shrira, Shmotkin, & Litwin, 2012).

Moreover, Brom, Kleber, and Van Den Bout (1993) and Prigerson and Jacobs (2001) maintain that there is no difference between pathological mourning and unprocessed trauma, even though the content of the experiences may differ. They see importance in relating to loss as a kind of trauma, and to relate to trauma as a kind of loss.

Loss and bereavement

'You are that what you cannot lose'.

Gerrit Komrij

(Smith, 2013)

Stroebe and Schut (2001) suggested some definitions for the central terms in this topic: '*Bereavement*' is the objective situation of losing a close-one; '*grief*' is the emotional response to loss; and '*mourning*' identifies the actions and mannerisms that express grief.

When people lose a loved-one, they embark on a difficult journey of the heart. They begin by suffering bereavement. Bereavement in its origin means "the state of being deprived". Bereavement deprives people of the living presence of someone they love (Attig, 2001). It tears their bonds with the people they love.

Davenson (2004) and Katz, Hockey and Small (2001) assert that bereavement of a loved one is an emotional response to loss which is a universal human experience.

Grieving is what people do in response to that happens to them in bereavement - they struggle to come to terms with the pain and anguish that accompany the devastation in their lives and the hard labor of grieving itself. People move from being their pain – being wholly absorbed in and preoccupied with it – to having their pain – to carrying residual sadness and heartache in their hearts (Attig, 2001).

Reactions to loss can be intense, as reflected in depressed mood, anxiety, sadness, lack of interest in re-engaging in the world or forming new relationships (Neimeyer et al., 2010). According to Freud (1912), following the loss occur a melancholic response which is manifested as heart-ache, disinterest with the world, inability to love and impairment of self-perception (Kogan, 2007).

Although most people successfully navigate bereavement and retain or return to pre-loss levels of functioning, a significant proportion struggle with protracted grief, and are unable to find meaning in the wake of an unsought transition (Katz et al., 2001).

Some people experience complicated grief, a well-documented psychological disorder characterized by severe and disabling responses to loss. In particular, individuals bereaved through deaths that are violent (e.g., homicide), unexpected (e.g., motor vehicle accident), or untimely (e.g., the death of a child) are at heightened risk of complicated grief reactions marked by an inability to accept the loss, preoccupation with the deceased, confusion about one's role in life, and loss of purpose and hope for the future (Stillion, 2014; Shanun-Klein, 2012; Neimeyer et al., 2010; Davenson, 2004).

Calhoun and Tedeschi (2001) say that like an earthquake's effects on physical structures, loss can shake, severely damage, or destroy the fundamental components of an individual's worldview and life narrative.

Theorists have argued that what makes traumatic events so distressing is that they violate many of the basic assumptions people have about themselves and the world (Janoff-Bulman, 1992; Parkes, 1988; Silver & Wortman, 1980; Taylor, 1983). Several theorists have proposed that people hold deeply ingrained beliefs that the world is benevolent, predictable, and meaningful and that the self is worthy (Janoff-Bulman, 1992; Taylor, 1983). These beliefs offer individuals a sense of security and invulnerability (Janoff-Bulman, 1992). Traumas, bereavement and other adverse events

profoundly challenge these beliefs and shatter our life assumptions and our takes-for-granted life patterns (Updegraff, Silver & Holman, 2008; Attig, 2001). Particularly, violent, sudden, or seemingly meaningless deaths can make the world appear dangerous, unpredictable, or unjust (Neimeyer et al., 2010).

To conclude, loss and trauma events often represent severe threats to how people perceive themselves and how they perceive the world. These events can shatter hopes, destroy confidence, and cast people into despair to last a lifetime. Epidemiological studies suggest that people who experience loss or trauma are subsequently at higher risk for a range of psychiatric disorders (Davis, 2001; Schnurr & Green, 2004; Pizarro, Silver, & Prause, 2006).

Additionally, a narrowing and diminishing in quality of life occurs for those affected by trauma, because the traumatic experience continues to haunt the victim in full force, preventing them from rejuvenating and continuing on their way, seeking challenges, love and a future (Schellekes & Dekel, 2001).

As described above and from the literature, trauma and loss have a substantial impact on victims. In the past decades several treatment methods and programs have been developed to treat traumatized people.

Trauma and loss treatment

'The very heart of psychotherapy is a caring, deeply human meeting between two people, one more troubled than the other'.

Irvin D. Yalom

(Yalom, 1989)

Littleton, Horsley, John, & Nelson (2007) suggest that there are two main groups of coping strategies within the trauma and loss treatments. The first group comprises of *Emotion-focused strategies.* These strategies focus on managing the emotional distress and include disengaging from emotions

related to the stressor, seeking emotional support, and venting emotions. The second group includes *problem-focused coping strategies*. These strategies directly address the problem causing distress and include seeking information about the stressor, making a plan of action, and concentrating on the next step to manage or resolve the stressor.

The main therapeutic theories and practices relate differently to trauma and loss, each offering a unique approach and a different practice. Here is a description of the main approaches and practices to trauma and loss treatment.

Psychodynamic psychotherapy

Psychodynamic or psychoanalytic psychotherapy refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than psychoanalysis proper. Session frequency is typically once or twice per week and the treatment may be either time limited or open ended. The essence of psychodynamic psychotherapy is exploring those aspects of self that are not fully known, especially as they are manifested and potentially influenced in the therapy relationship (Shedler, 2010).

Shedler (2010) suggests that there are seven features which distinguish psychodynamic therapy from other therapies: focus on affect and expression of emotion, exploration of attempts to avoid distressing thoughts and feelings, identification of recurring themes and patterns, discussion of past experience (developmental focus), focus on interpersonal relations, focus on the therapy relationship, and exploration of wishes and fantasies.

Psychodynamic modes of treatment have long been in use for traumas and have been historically applied to PTSD or differential diagnoses (Ogburn, 2015). In trauma-focused psychodynamic therapy for PTSD, the therapist overreaching objective is exploring the personal meaning of the traumatic event. Specific attention is devoted to examining the impact of the event on the self-concept and views of others, as well as defensive maneuvers being used to ward off painful emotions and nihilistic, frightening or hopeless meanings attributed to the trauma or its aftermath. Support, advice, active expressions of empathy, and education can also be crucial components of this kind of treatment (Marshall, Yehuda, & Bone, 2000).

CBT (cognitive-behavioral therapy)

CBT is a collaborative, structured, skill-building, time-limited, and goal-oriented intervention designed to target core components of a given disorder (Hollon & Beck, 2004; Olatunji, Cisler & Deacon, 2010). Conventional CBT is best defined as a group of therapeutic approaches sharing a common philosophical belief that emotional and behavioral experiences are caused by thoughts, beliefs, and cognitions rather than external events (Field, Beeson & Jones, 2015). As a collection of treatment approaches, CBT is considered as one of the popular treatment approaches in clinical practice guidelines for PTSD by the American Psychiatric Association (McLean & Foa, 2011). The components that typically constitute CBT for PTSD include psychoeducation, anxiety management, cognitive reconstructing, and exposure (Bryant, 2004; Seidler & Wagner, 2006).

PE (prolonged exposure) therapy

PE is based on the CBT philosophy. It is a manualized treatment package that consists of 9 to 12 sessions. The first two sessions include information gathering and psychoeducation. The later sessions include repeated imaginal exposure to the trauma and assignment of in-vivo exposure homework to avoided trauma cues (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). The overall aim of PE is to help trauma survivors emotionally process their traumatic experiences in order to diminish PTSD and other trauma related symptoms (Foa, Chrestman & Gilboa-Schechtman, 2008; Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010).

EMDR (eye movement desensitization and reprocessing)

EMDR is an exposure treatment in which patients perform saccadic eye movements while thinking about a traumatic experience (Van der Kolk et al., 2007). As indicated by Solomon (2002), the psychological and emotional arousal stemming from a traumatic event may disrupt the information-processing mechanism. EMDR organizes the memory selected for processing, catalyzes the information-processing system, maintains it in a dynamic state, and facilitates the processing of the information surrounding the event.

In an EMDR session the client is instructed to focus both on a disturbing image or memory and on the emotions and cognitive elements connected with it. Once the client has established contact with the disturbing material, the therapist induces a bilateral stimulation. The simplest method involves moving the fingers back and forth in front of the client's face after instructing the client to follow the movement with his/her eyes. Bilateral stimulation can also be induced through auditory or tactile stimuli (Seidler & Wagner, 2006).

Rather than providing a chronological narrative of the details of the traumatic event, as is done in CBT, EMDR patients are encouraged to follow their own course, moving freely backward and forward

in time, attending to inner sensations and cognitions, omitting verbal communication about content if they wish (Van der Kolk et al., 2007).

Narrative therapy

Narrative therapy is an approach that focuses on client stories with the goal of challenging existing meaning systems and creating more functional ones (Kropf & Tandy, 1998). This approach is a postmodern theory emphasizing problem-saturated stories. Merscham (2000) suggests that experiences are mapped into stories that constitute reality, and these stories are constructed through language and are influenced by unique life situations such as culture, upbringing, religion, and gender. The presenting problem the client reveals is seen as their problem-saturated dominant story. The therapy is based on the principle that in the process of putting an experience in the form of a story; certain parts are left out because they are less attended to than other parts. These become neglected pieces of the stories (Dwivedi & Gardner, 1997). Since people often focus on problems or negative aspects of their experience, these become the dominant plot in their experience. During therapy, as patients are encouraged to attend to the neglected parts of their experiences they can formulate a more complete story and then are able to see new meaning in their experiences (Petersen, Bull, Propst, Dettinger, & Detwiler, 2005).

Meaning making approach

Meaning making theory emphasizes the importance of working to restore global life meaning when it has been disrupted or violated, typically by a major schematic of global meaning and situational traumatic life event. Park (2010) asserts that according to meaning making hypothesis, facilitating or encouraging people's cognitive processing of a difficult experience will eventually give rise to changes in their situational meaning, their global meaning, or both. Continued cognitive processing of the stressful situation should enable people to change their views of it toward less distressing and more easily assimilated ways of thinking about it, which should reduce distress and, eventually, reduce the need for cognitive processing (Park & Blumberg, 2002).

Meaning making during therapy involves coming to see or understand the situation in a different way and reviewing and reforming one's beliefs and goals in order to regain consistency among them. The processes through which people reduce this discrepancy involve changing the appraised meaning of the situation and changing their global beliefs and goals, in order to integrate the appraised meaning of the event and their global meaning system (Klinger, 1998; Park & Ai, 2006). Since trauma has the potential to create Chaos in victims' lives, telling stories about suffering and pain may create order and contain emotions, allowing a search for meaning and enabling connections with others (Riessman, 2008; Rogobete, 2015).

Buddhist psychotherapy:

The Buddhist approach to trauma and grief psychotherapy is distinct from most Western ones (Kinzie, 1989). Buddhism is the ethical psychology based on Buddha's discoveries and offers a range of therapeutic methodologies. Buddhist psychology has a distinctive, theoretical framework that offers some advantages in the conceptualization of traumatic change both from the perspectives of subjects and of therapists (Rubin, 2013).

From the Buddhist perspective, the pain of loss and trauma are essentially the stress of coming to terms with what life really is and involve the challenge of letting go people's long-cherished illusions (Brazier, 2007). Trauma brings up energies that feel as if they threaten to overwhelm a person. Commonly the individual seeks to cope by anchoring him or herself to some source of comfort or distraction. This, however, only compounds the problem. The Buddhist psychology focuses on helping the person to experience the traumatic shock as an opportunity, not merely a disaster (Siegel, Germer & Olendzki, 2009).

An integrative model, combining different psychological approaches was suggested by Tuval-Mashiach et al. (2004), who based on the experience accumulated in Israel assert that there are three crucial factors for effective coping with trauma and loss. The first factor is continuity and coherence, i.e. the ability to maintain a sense of continuity (at both the level of the general life-trajectory and the specific, concrete trauma). Maintaining continuity and coherence is considered a prognostic sign of better recovery. The second factor aimed at therapy is the creation of meaning, i.e. that the coping process includes an active search of the survivor for meaning to the events. The third factor is self-evaluation, e.g. degree of control; feeling guilty or responsible; and being active or passive. These aspects of self-evaluation related to the traumatic event have been shown to correlate to efficacy of coping.

Lastly, a less clinical approach was presented by Van Der Merwe and Vienings (2001), who propose that there are three key elements in helping a person to deal with trauma. The first is getting the person to talk about what happened to them and to tell their story in detail. Another key element is that the person providing the help will reframe the victim's perceptions of his or her role in the event. And finally, the helper should assist the victim in developing and sustaining coping mechanisms.

Today, the mental health realm offers numerous and varied approaches and practices to trauma and loss treatment. Yet, as Keinan (2012) emphasizes, trauma and loss harm the ability of the victim to maintain interpersonal relationships and therefore also limit their ability to seek assistance. Most victims do not get to therapy, and their lives become a constant effort to dull their pain, while the trauma and the loss consume a considerable part of their psychic energy (Doron, Melamed, & Bleich, 2006).

Trauma and loss are universal phenomena resulting in common human distress. Yet, these events might also have some unique aspects. Research shows that trauma and loss due to terror and war have distinctive impact.

Many investigators have examined the mental health consequences of exposure to war/terror trauma and found substantial post-war psychiatric difficulties among veterans (Falger et al., 1992; Ursano, 2002; Ford et al., 2001; Hoge, 2004; Koren, Norman, Cohen, Berman, & Klein, 2005; Pizarro et al., 2006).

In addition to that, many studies link emotional stress, such as terror and combat, to mental health problems. People in war zones and combat soldiers are more likely to develop PTSD. The prevalence rates of PTSD in war zones civilian population and combat soldiers population varied from fifteen to thirty percent (Wittchen et al., 2013; Horesh, Solomon, Keinan, & Ein-Dor, 2013; Hoge, Riviere, Wilk, Herrell, & Weathers, 2014).

Similarly, a review of studies by Neria, Nandi, and Galea (2008) indicates that among those directly exposed to terrorist attacks, PTSD incidents may reach 20–25 percent, while fewer than 5 percent of the general population may develop PTSD. However, terrorism, yielded the severest levels of psychopathological impairment (not PTSD), for over 50 percent of the population (Dechesne, 2012).

Considering Dechesne's (2012) claim that over 50% of the population exhibit psychopathological impairment as a result of terrorism, there is a need to specifically address terror related trauma as a somewhat unique phenomenon.

In countries, such as Israel, where the occurrence of terror and war is very frequent, and affect not only combat soldiers but also the civilian population, the consequent trauma effect should be considered also from a national-psychological perspective.

National trauma

'It is such a mysterious place, the land of tears'.

Antoine de Saint-Exupéry

(De Saint-Exupéry, 2013)

Husain (2012) claims that today, the greatest problem the world is facing is terrorism in one form or another. Terrorism and hatred seek to create chaos and uncertainty all over the globe, while unrest and protests are raging across countries and continents. Terrorist attacks require our health care system to prepare for the unspeakable, since the primary goal of terrorism is to erode the security of a nation, to disrupt the continuity of society, and to destroy the nation's social capital—its cohesion (Ursano, 2002). In light of this global contemporary problem, which seems to be escalating in recent years, professionals from varied fields of expertise ought to concentrate efforts in developing resources to best cope with this immense challenge.

Mental health professionals must deal with the psychological and social impacts of terror because of the understanding that central human expectations that bodies remain intact, the world is safe, life is fair, and so on are clearly invalidated by situations of war, terrorism and similar such events (Sewell & Williams, 2001). They also suggest that social disruption involves invalidation of anticipations regarding “with whom and how I am socially related”.

The term “basic trust”, coined by Erikson (1960), relates to the sense of safety in the world which develops through the relationship with the first caregiver (usually a parent), which supports a person throughout his life and forms the basis for all other relationships.

In situations of fear/terror, people call out to their mother or to God. When their call elicits no response, their basic trust shatters, and from there on, feelings of alienation and detachment permeates all of their relationships, from their close family to their ties with the community (Herman, 1994).

Herman (1994) was one of the leading professionals to explore, theorize and treat trauma victims, particularly war related trauma. In her iconic book, "trauma and recovery" Herman explicitly drew a link between the traumatized individual and his surrounding family, community and society. Yet, Herman confined this link to the role of the community to the recovery of the individual. She was concerned with the potential beneficial impact of the society on the individual, but not on the potential destructive impact it might also have. It is reasonable to assume that if society has such potentially

positive power on the individual; it has also the same potentially negative power when it doesn't serve its purpose.

Some scholars connect an expansion of trauma discourse with the development of humanitarian institutions as the response to political violence (Breslau, 2004). "Nationalization" of trauma could be seen as a new stage in the history of trauma discourse. Since the second half of 19-th century there has been considerable diversity in the main topics of trauma discourse, in the events and situations that have been perceived as traumatic, and in the social groups recognized as trauma victims (Brunner, 2002).

Practitioners' experience indicates that the state is perceived as a parent whose duty it is to care for his "children" and protect them from potential harm. However, this "parent" has failed in upholding its responsibility: Innocent civilians are hurt, both physically and emotionally, and they do not feel safe and protected at their own homes. The absence of personal security and the disruption of ordinary life create frustration, anger and mistrust in the government in particular and the establishment in general (Tamir & Haimov, 2005; Friedman-Peleg, 2014).

The Israeli situation and NATAL

Plotkin-Amrami and Brunner (2015) assert that in Israel, the establishment of a new institution, NATAL, oriented to research, treatment and prevention of the effects of "national trauma", may be seen as an indicator that "national trauma" is a real category of victims which are the object of professional theory and practice. Indeed, the professionals at NATAL were trying to identify and define this then unrecognized phenomenon - Prof. Avi Bleich (Bleich, 2004), the head of NATAL's Steering Committee, said that "National trauma is something that has to be defined. One of my primary goals is to define this issue because when we speak of trauma of national origins we also refer to an additional aspect - to our feeling of identification and belonging. Trauma of national origins would be that which we experience from the mere fact that we belong to a certain nation'' (Plotkin-Amrami & Brunner, 2015).

When NATAL was established, the very process of the creation of the category was perceived as problematic, as this process requires the discipline, whose conventional analytical unit is the individual psyche, to relate to the collective-nation, i.e. "society" as new analytical unit. It required borrowing terms from the clinical field to social processes (Grinfeld, 2003).

At first, NATAL (in 1998) was the only organization in Israel publically raising awareness to the existence of national trauma. At times, it was criticized for that. Yet, as terror attacks increased in Israel, in the early days of the Intifada, Israeli experts with the help of the New- York Federation created the “Israel Trauma Coalition (ITC)” – a national continuum of organizations that seek to offer effective trauma care to all Israeli citizens (Plotkin-Amrami & Brunner, 2015).

Reality forced mental health professionals in Israel to acknowledge national trauma and develop professional tools to treat people affected by it. Similarly, in 2001, after the terrorist attacks in 9/11, there has been a global change in that regard. As a result, over the last decade the use of the term "national trauma" has become universal following the acts of mass terrorism perceived as threatening to destabilize collective identities of entire populations. The term "national trauma" is usually adopted by American experts to signify a large scale traumatization due to the "unprecedented in its scope and traumatic impact" of the terrorist attacks of September 11 (Silver et al., 2005).

It seems that "national trauma" has become a new object of professional discourse both in American and Israeli mental health discourse. Mental health practitioners began investing institutional, research, and clinical resources in order to both detect the effects of "national trauma" and provide professional aid to its victims. Indeed, even mental health practitioners, who's conventional object of intervention is an individual psyche rather than national collective, have now embraced this new category (Plotkin-Amrami & Brunner, 2015).

The assumption underlying NATAL's activities is that trauma in national context has unique features and that psychological assistance and care offered to victims should be adapted accordingly.

Reality has shown that the large numbers of traumatic events and victims in Israel make it difficult for the authorities to provide fast and efficient response to some victims. Many victims feel fatigued by the bureaucracy and the dismissive attitude. There is no real understanding of their suffering, and at times they may even sense disrespect and unreceptiveness. As Keinan (2012) stated: ''the bond between the victims and the authorities responsible for treatment is still far from being satisfying.''

Since many of those who turn to NATAL are disappointed, having despaired with the way the authorities have addressed their complaints, there is a need to rehabilitate and rebuild their trust in others, in society and in its establishments, to support and accompany them through the processing of the experience of trauma or loss, and to provide them with tools to return to life with a purpose. Field practice has shown that a single telephone call would usually not prove effective in such cases, and may even lead to the opposite result to the one that is desired–it may create in the caller a sense of ''I did my bit'', leaving them with their loneliness, anxieties and pains, ''left behind on the battlefield'', with responsibility removed and their experience ignored (Tamir & Haimov, 2005).

This is the reason for NATAL's helpline unique intervention model, which is essentially different from most helplines in Israel or around the world. This model–the longitudinal intervention model–was developed with the aim of offering unique response to victims of trauma and loss. The longitudinal intervention model offers a continuous bond – repetitive showing of interest in the caller, listening to their story, angers and deliberations, legitimizing their feelings and providing them with support in

difficult times. It aims to provide callers with a sense of caring, concern, and an authentic and constant desire to be there for them.

This chapter presented the field of trauma and loss by providing a literature review of the existing research. Also, it described how this knowledge led to the attempt to provide the service of the helpline. Before the helpline can be presented, the next chapter will provide additional contextual information, by reviewing the literature related to phone interventions.

Chapter 5

Phone Interventions

The emergence of crisis interventions and telephone counseling services

'I have seen many storms in my life. Most storms have caught me by surprise'.

Paulo Coelho

(Coelho, 1988)

Since the invention of the telephone by Alexander Graham Bell in 1876, its use had spread into almost every aspect of life. It is difficult to imagine our daily routine without this communication device, which brings those who are far close to us and enables conversation with them.

In the late 1950s, helpline and crisis hotlines emerged, almost simultaneously, in 3 major places – England, Australia and the United States:

Chad Varah, an English vicar, was the first person to utilize the telephone as a device for providing psychological assistance: The confession booth was replaced by the telephone, and so the anonymous caller could relay his or her woes to an unknown listener, who had heard and responded to what the caller had said. Varah established the Samaritans organization, which was the first organization to utilize the telephone as a tool for providing assistance in time of personal crisis (Karon, 1991; Raviv, 2000).

In 1958 the Reverend Alan Walker of Sydney's Central Methodist Mission was appearing on a weekly evangelical radio and television program. His appearances on television and radio prompted a significant number of people in crisis to telephone him directly and seek advice. The demand for help via the telephone prompted Walker to find a unique telephone counselling service. Established in 1963, Lifeline provided a new model of social support for people in distress. Within days of commencing operation in Australia, the helpline had received more than 100 calls (Wright, 2008).

A major stimulus for the development of telephone counseling in the United States was the opening of the suicide prevention in Los Angeles in 1950 and the decision to adopt the telephone as the primary mode of treatment due to its immediacy (Lester & Rogers, 2012). Also, in different cities across the Unites States, several organizations started offering telephone helplines for suicidal people, which then became a part of the local community mental health services (Wright, 2008).

Although crisis hotlines spread to many countries around the world, it was not until the 1970s that helplines began to diversify and extend beyond the already well-established area of emotional crisis-counselling (Firth, Emmison & Baker, 2005).

Hutchby (2001) claims that in many respects the telephone (like the automobile and the television) is emblematic of twentieth-century living, and today – as a result of the popularity of cellular telephones – it has become commonplace in virtually all spheres and contexts of daily life. The telephone has brought about major changes in ways of living, as people have learned to exploit the advantages of communicating not only 'at a distance' but also 'on the move' (Firth et al., 2005).

The sectors of healthcare, therapy, counseling and rehabilitation are heavily influenced by the latest technological developments, as the use of telecommunication devices (i.e. telephone, fax, email) has become more prevalent and popular as a means for providing assessment, counseling and therapy (Coman, Burrows, & Evans, 2001; Maureen & Adriana, 2004; Heidi, Robert, & Eric, 2002). The telephone is the easiest to use as well as the most common, immediate and uncostly (Haas, Benedict, & Kobos, 1996).

Definition of phone interventions

Presently there is no universally accepted definition or term for providing therapeutic and counseling services over the telephone. Policy makers, legislators and telephone service providers use various terms such as 'tele-health', 'tele-medicine', 'tele-psychology', 'tele-psychiatry', and 'tele-mental health' (Baker & Bufka, 2011). All of these various terms refer to utilization of technology as a means to provide medical or psychological services remotely, as a replacement for or in addition to face-to-face intervention (Brenes, Ingram, & Danhauer, 2011; Harwood et al., 2011).

Williams (2000) describes Telepsychology as healthcare professionals (psychologists) interacting with their clients using real time interactive communication media. Included in this definition are telephone (audio only interaction), Internet chat rooms, video and audio transmission via the Internet.

Telehealth and e-health are terms used to describe any health related service that is provided remotely via technology-assisted media such as the telephone, computer, or Internet. Telepsychology is one form of Telehealth service that is related to remote psychological services. Other terms also commonly used are e-psychology, e-counselling, web-counselling, telephone counselling or online counselling. All of these terms reflect the nature of remote psychological services (Campos, 2009).

In this thesis phone intervention is defined as the provision of psychological services, remotely via the telephone, through real time interactive communication between a helpline specialist and a caller/client.

Significant developments have been made over the past decade in this field. Present-day telephone interventions vary widely, ranging from providing information to psychological and / or psychiatric

treatment (Campos, 2009). Therefore, phone interventions and services have many specific characteristics and may vary in type and nature. Below, specific characteristics of phone interventions will be elaborated.

Characteristics of telephone services

'The universe only makes sense when we have someone to share our feelings with'.

Paulo Coelho

(Coelho, 2003)

Categorization of different types of telephone services

Currently, Telepsychology has integrated into traditional health services. However, the evolving nature of technology which has facilitated interaction of the client/professional relationship means that Telehealth can be viewed as separate or alternative services to mainstream health delivery systems (Turner, Sloan, Kivlahan, & Haselkorn, 2014).

Bobevski, Holgate and McLennan (1997) suggest a classification of telephone counseling services to three categories: the first refers to relatively large agencies which provide a general 24-hour telephone counselling service to members of the community at large (e.g. the Samaritans in Great Britain, Lifeline in Australia).

The second category includes many agencies which provide very specific telephone counselling services for those with particular needs, such as: individuals who are alcohol or drug dependent, people affected by AIDS, victims of sexual assault, compulsive gamblers, survivors of childhood sexual abuse, etc. These services sometimes operate on a 24-hour basis but usually on a more restricted basis.

The third category of services involves many health and welfare agencies which offer telephone counselling within normal business hours as one aspect of the overall range of services available.

At present in Western Europe and other developed areas of the world, the telephone-based services sector is one of the major sources of employment. In the UK alone there are currently over fifteen hundred helplines in operation (Firth et al., 2005).

Helplines are dedicated telephone-based services that provide assistance and/or guidance on a plethora of topics and concerns, ranging from emotional to legal, technical to financial, medical to strategic, mundane to bizarre. Helplines have grown exponentially over the last two decades and have become increasingly more specific in terms of their areas of concern; there is an array of specific and dedicated helplines covering the gamut of social and psychological concerns (Firth et al., 2005).

Several researchers discuss warm lines (contrarily to helplines) and refer to the fact that they have emerged within the past decade to compensate for shortcomings of existing professional programs. Both hotlines and warm lines mediate between a person's need for help and their reluctance to turn to the bureaucratic entanglements of existing health and social services. Both operate "after hours" when therapists, counselors, and other mental health support staff are not available. Yet, warm lines differ from help lines because their main objective is listening and supporting, not referring or advising:

Pudlinski (2005) claims that in contrast to crisis hotlines, warm lines have three defining characteristics: they are a peer-run, pre-crisis service, and designed for providing social support.

As a pre-crisis service, warm lines let clients discuss issues before they become serious. Helpers are instructed to forward or refer the occasional crisis call to an associated crisis hotline service. Warm lines thus differ from crisis hotlines as "hot" calls, including suicidal issues and other urgent problems, are typically not dealt with by the warm line. Nonetheless, warm lines play a beneficial role in crisis prevention (Klein, Cnaan, & Whitecraft 1998); they permit hotlines to deal more exclusively with urgent problems and have led to a reduction of crisis calls from the community mental health clientele.

Anonymity in the context of phone interventions

A general characterization of helplines (particularly those concerned with physical and mental health, grief, crisis, divorce, addictions, phobias, trauma, and law) is their overriding tendency to emphasize the fact that call-takers and callers are, and will remain, personally *anonymous* to one another. Call-takers may not, strictly speaking, be completely anonymous, but exceptionally few helplines operate

where call-takers disclose their full names or other distinctive markers of their individual identity. In most cases, helpline call-takers will use their first names only, when engaging with callers, and will resist callers' requests to reveal their full names or other identity markers (Firth et al., 2005).

Agarwal, Liu, Murthy, Sen and Wang (2009) propose that as the world around us continues to grow; individuals begin to see themselves as a stranger in society and everyone around them strangers to them. 'Familiar stranger' refer to a visual but not verbal relationship in which both parties maintain anonymity. These are people who aren't totally unknown but aren't acquaintances either. This view might be relevant to helplines: helplines – particularly those providing emotional counselling – appear to offer what might be called *intimate anonymity*. This corresponds with the well-known study of Lyn H. Lofland (1985) – *'A World of Strangers*'. She argues that the post-industrial age is characterized by the individual's routine though transitory engagements with 'anonymous others' who act in some kind of 'official', information-giving capacity. We are socialized into inhabiting communities of 'strangers', and see such an existence as 'routine' and 'ordinary'. Telephone helplines are in many ways an exemplification of this 'world of strangers', where the 'strangers' in this case regularly engage with one another over matters of an intimate nature (Zhao, 2006).

Phone intervention as real-time interaction

Firth et al. (2005) suggest that the telephone allows for synchronous, real-time, conversational interactions (while the participants do not have visual access to one another).

Glueckauf, Whitton, & Nickelson (2002) define synchronous communication as: information transactions that occur simultaneously among two or more persons. Similarly, Pennings et al. (2014) emphasize that experiences and processes on a real-time level denote what happens within or between humans from second to second.

Synchronous technologies allow people to communicate simultaneously, in real time, which is to say that responses to questions are immediate. Telephone conversations are a basic example of synchronous communication (Alessi & Trollip, 2001).

Regarding the field of counseling, the NBCC - National Board for Certified Counselors (2001) propose that synchronous (real-time) interactions occur with "little or no gap in time between the responses of counselor and client". In the same way, Osenbach, O'Brien, Mishkind and Smolenski (2013) determine that synchronous Tele mental health modalities allow for real-time auditory and/or visual interaction between patient and provider. These modalities provide the closest approximation to a traditional, in-person encounter.

Coman et al. (2001) categories telehealth services by the type of interaction and the longevity of the interaction. That is, the type of interaction is either recorded or live and the longevity of interaction is either ongoing or crisis (Campos, 2009).

Telecounseling can be asynchronous (store and forward) or synchronous (real-time). Synchronous modes are currently more viable modes of long-distance communication. Common forms of synchronous telecounseling are televideo, telephone, and interactive text messaging. One advantage of real-time telecounseling is that decisions may be made immediately at the time of the session (Baca, Alverson, Manuel, & Blackwell, 2007).

To conclude, many scholars agree that the most common form of synchronous communication is the telephone (Glueckauf, 2002; Baca et al., 2007).

Modus operando/Practice

Phone interventions operate in different ways and have different purposes. The next paragraph will describe what helplines do and their method of operating.

Firth et al. (2005) put emphasis on a central feature of helplines, and claim that helpline users – callers and call-takers, on either end of the line – talk to one another. Talk is the help of helplines. Help is accepted and provided through talk, talk that occurs in real-time, in the dialogic processes of focused social interaction.

Considering the act of 'talking', Wright (2008) claims that anything ever said is said by someone, to someone, at a particular moment of some specific socially organized and culturally informed occasion.

The similarities between the definitions provided by Wright (2008) compared to Firth et al. (2005) may lead to an even larger question regarding the connection between 'talk' and 'therapy'/'help' – is therapy/help merely talking ?

There is agreement in the professional literature that talking is not only something that can make people 'feel better', but it is also a practical intervention that is able to effect change and resolve problems. Also, that 'getting things off your chest' is not only liberating and empowering, but is one of the most popular strategies in the repertoire of self and relationship management (Moerman, 1988; Wright, 2008; McLeod & Wright, 2009).

In summation, 'talking' with someone, possibly at a helpline, serves as a ventilating and cathartic act, but may also be a productive emotional resource for managing difficult circumstances.

Moreover, McLeod and Wright (2009) suggest that the rise of therapeutic culture instigate cultural fascination with confessional narratives and strategies for better understanding the self. Therefore, there appears a diverse range of social practices and cultural discourses unified by the imperatives of talk and self- disclosure.

It can be suggested that helplines, though emerging many years ago, have flourished in recent years as a result of this therapeutic culture trend.

Although there is a consensus regarding callers' needs and focus on communication and disclosure when calling helplines, the role and practice of the helpline specialist is not as clear.

Mishara et al. (2007a) maintain that despite the proliferation of telephone helplines, there are no standardized protocols describing how telephone helpers should interact with callers. Some tend to engage in nonjudgmental active listening as a primary method, some tend to focus more on defining problems, finding solutions, and making referrals as part of what can be called a collaborative problem-solving approach.

Addressing this dilemma, Dinakar, Chaney, Lieberman and Blei (2014) propose three key responsibilities of the phone counselor. First, the counselor performs a risk assessment to discern if the caller is at grave threat to themselves or to others. Usually, callers are categorized into high, medium and low risk buckets. Furthermore, the counselor's second responsibility is elicitation of issues which are causing the crisis for the caller. Finally, the counselor is expected to project empathy and formulate an action plan in order to make the caller feel their plight is understood and their difficulties acknowledged; an action plan of simple steps to help the caller tide over their crisis.

Other frameworks for practice are suggested by James (2008), Kitchingman, Wilson, Caputi, Woodward, & Hunt (2015) and Sands et al. (2013). Most models outline several main tasks to be accomplished during such an intervention - the counselor is first expected to connect with the caller and establish rapport, then there is a need for focusing the conversation which is achieved by identifying and defining the caller's problem. Once the first two steps were attained then there is an effort to relieve the caller's distress, providing support and ensuring safety. The final step is usually aimed at creating a plan of action to enable coping and enhance the resourcefulness of the caller.

To conclude, there are different helplines which offer diverse services aimed at different purposes. Helplines do not have shared or universal operational model and framework. The different models suggest different paths and different emphasis, yet there are core similar characteristics that can be found in all of them.

Continuity and comprehensiveness of care

Continuity of care is the degree to which healthcare services are coherent, connected and consistent with the patient's medical needs and personal context. Continuity of care consists of two core elements—care over time and the focus on individual patients (Haggerty et al., 2003).

Freeman et al. (2001) found that the three most common definitions of continuity of care are: longitudinal or provider continuity – seeing the same professional, continuity across the secondary/primary care interface (i.e. concerning discharge from specialist to generalist care, and continuity of information through records – either written or electronic).

Regarding phone interventions, Bobevski and McLennan (1998) propose that most telephone crisis calls are one-off events, with no opportunity for follow-up contact.

Indeed, many scholars (Raviv, 2000; Lester & Brockopp, 1973; Campos, 2009) claim that none of the contemporary crisis counseling programs satisfies a criterion of comprehensiveness of care, because of the short-term, time-limited character of their services.

Notably, phone interventions aren't similar to other mental health interventions and therefore have unique advantages and disadvantages, which are described in the next paragraph:

Advantages and disadvantages of phone interventions

'How can one be indeed near unless he be far?'

Kahlil Gibran

(Gibran, 2013)

The first advantage of using the telephone to provide assistance is immediacy. Nowadays, people value the ability to obtain services and replies immediately (Wang, 2000). Additionally, in many cases of crisis, the effectiveness of assistance depends on its immediacy (Lester, 1995), and thus the telephone provides an effective response to acute distress (Paukert, Stagner & Hope, 2004).

Another advantage of phone services is its convenience for users who perceive such assistance to be a convenient solution as it saves in many cases the need to pre-plan, set up meetings or having to experience bureaucratic delays (Haas, Benedict, & Kobos, 1996). Additionally, the caller does not have to leave their home, and therefore it is more convenient for them to take part in the process (Karon, 1991; Baca et al., 2007).

The accessibility of such services is an advantage for callers who find it easier to contact the service (Bee, Lovell, Lidbetter, Easton, & Gask, 2010; Mohr et al., 2005; Masi & Freedman, 2001) and allows overcoming barriers such as geographical distance or disabilities related to physical movement (Al-Karnawi, Graham, & Fakher-Aldin, 2003). Many researchers assert that the accessibility of telephone therapy is a significant advantage for callers with physical ailments, or those who are shy, anxious or agoraphobic (Riemersma & Leslie, 1999; McNamee, O'sullivan, Lelliott, & Marks, 1989; Dorstyn, Mathias, Denson, & Robertson, 2012).

A fourth advantage of phone interventions is its lack of stigma: for some people, requesting therapy means admitting failure and defeat. Since many people are deterred from requesting psychological treatment due to the stigma attached to it (Bee et al., 2010; Gil, 2002; Mohr et al., 2005; Mozer, Franklin, & Rose, 2008), many end up not receiving the help they require. These people usually perceive a telephone call as less stigmatic (Chavan, Garg & Bhargava, 2012) and a less intimidating experience (Coman et al., 2001; Karon, 1991), with telephone therapy for them being a 'middle of the road' solution (Gil, 2002). Therefore, telephone intervention can be a gateway for people who would otherwise not get direct information, referrals or treatment (Al-Karnawi et al., 2003).

Another advantage relies on the fact that telephone therapy allows the caller to retain their privacy (Haas et al., 1996) and anonymity (Masi & Freedman, 2001). Due to the remoteness and refuge provided by the telephone, callers can feel protected and therefore their willingness to make contact

and open up is greater (Karon, 1991). Additionally, people experience a higher sense of privacy on the telephone, since the patient can speak with the therapist without someone else seeing them at the therapist's office or on their way to or from there (Wang, 2000).

Cost is another significant advantage of telephone therapy, which is less costly than traditional psychotherapy (Harwood et al., 2011). In economic terms, it incurs relatively low cost for the organization and low cost or no cost for the caller (Al-Karnawi et al., 2003). Due to its low cost, more people can benefit from therapeutic intervention (Heidi et al., 2002; Masi & Freedman, 2001), especially people belonging to lower socio-economic strata, who usually cannot finance traditional therapy services due to their high cost (Maureen & Adriana, 2004; Paukert et al., 2004).

Alongside all that was said above, there are also some difficulties with telephone interventions, such as the low level of commitment from the caller. The caller may decide to disconnect the call at any inappropriate time. Additionally, due to the anonymity and the principle of not asking callers for personal details, it is difficult to perform any follow-up on the results of intervention or receive feedback regarding it (Raviv, 2000).

Another disadvantage relates to a perceived limitation of the medium (phone). Since the only source of data the helper has is the caller's voice and intonation, the telephone transmits a very small part of the wealth of non-verbal information that exists in face-to-face interaction (Raviv, 2000; Bobevski & McLennan, 1998). There is no way to receive information from non-verbal sources, such as facial expressions or body positions, there is no other visual-sensory information available and thus a limitation is formed with regards to the ability to assess to what extent the intervention was accepted and received by the caller (Haas et al., 1996).

Phone interventions vs. face-to-face interventions

Face-to-face describes social interaction carried out without any mediating technology. Face-to-face interaction is primal and primary, reflecting the basic human tendencies toward physically present social interaction. Historically, mediated communication was much rarer than face-to-face, yet today it is the other way round (Olick, Vinitzky-Seroussi, & Levy, 2011).

Face-to-face is considered as more personal form of therapy, hence the expression "in-person psychotherapy". Many mental health professionals consider it to be superior to remote/mediated therapy because it allows the therapist to assess the "whole" person - the patient's body language as well as the things they say and the things they find difficult to talk about (Turner, 2002).

Despite the practical advantages of utilizing technology for providing remote therapy (Jerome & Zaylor, 2000), practitioners are at odds with regards to the appropriate use of the telephone in therapy (Harwood et al., 2011). Since the telephone relationship is not considered to be an adequate

replacement for face-to-face interaction between the therapist and patient (Haas et al., 1996), practitioners tend to assign to telephone conversations a merely supportive value (Gil, 2002). This attitude is reflected in the debate taking place in the professional literature regarding the role of helplines–and whether professionals should provide counseling and therapy or just provide social support (Lazar & Erera, 1998).

The main criticism leveled at providing telephone assistance concerns the absence of a face-to-face encounter: The claim is that this harms the bond between therapist and patient and that it is an unnatural situation which does not resemble reality– ''Telephone counseling is suitable for verbal types who do not necessarily require face-to-face interaction'' (Haas et al., 1996).

Not only is this claim unsupported by testimonies from the field, but moreover, many studies exist that contradict it. Reese, Conoley and Brossart (2002) carried out a study comparing the effectiveness of therapy between telephone and traditional face-to-face methods, and showed that it was possible to establish a therapeutic alliance between therapist and patient using the telephone as a therapy module. Some studies showed that using the telephone as a tool for providing therapy does not affect the impact of therapy (Heidi et al., 2002), while others showed that the strength of the therapeutic alliance in telephone therapy is similar to that of face-to-face therapy (Beckner, Vella, Howard, & Mohr, 2007; Brenes et al., 2011).

Additionally, the claim regarding the disadvantage resulting from the absence of a face-to-face encounter does not sit with one of the principles of psychoanalytic therapy originally set by Freud (1912). Using the therapeutic sofa, Freud successfully prevented eye contact between therapist and patient, as well as the effects of body language and facial expressions on both patient and therapist, letting vocal communication transfer all the different shades of intonation. Psychoanalysts therefore sit behind their patients, so that the former may become formless voices (Gay, 1993)

It therefore seems that the substantial barrier to telephone therapy arises from a common perception among therapists that eye contact with clients is essential for effective intervention, from their work habits and from the personal need of the patients (Lindon, 1988). Accordingly, a study carried out by Hufford, Glueckauf and Webb (1999) showed that experienced practitioners who provided telephone therapy reported experiencing an interruption to their interaction with patients and doubted the quality of therapy that they had provided. Ironically, the telephone patients did not share this underestimation regarding the therapy they had received.

Perhaps part of the difficulty experienced by the therapists stems from the fact that telephone therapy allows the patient more control over the interaction (Haas et al., 1996). Telephone patients experience a sense of control and empowerment which comes from the nature of the telephone service and they express a sense of confidence which is the result of the ease in which they can end the telephone conversation whenever they may wish to do so (Coman et al., 2001). Telephone assistance allows for better balance and equality in power and control over the situation between

therapist and patient (Brenes et al., 2011), this because it takes less interpersonal effort to end a telephone conversation than to leave a therapy room, and therefore the caller experiences a greater sense of control (Gil, 2002; Mermelstein & Holland, 1991; Wang, 2000).

Williams and Douds (2012) claim that most systems of psychotherapy assume that face-to-face interaction is necessary for effective therapy - an assumption that is taken for granted as a *sine qua non* for "genuine therapy". A face to face interview is called therapy, but a telephone conversation is often given a status of a "contact", as if it does not deserve recognition as equivalent to a genuine therapy session. Although a telephone contact is accepted as better than nothing, it is judged to be depersonalization of true therapy.

In conclusion, one of the universal basic human needs is to share experiences and emotions with other human beings (Maslow, 1954; Max-Neef, 1991; Tay & Diener, 2011). This basic need is usually fulfilled by our family, friends, and community. When people are in need of sharing but for some reason find it difficult to get that resource then they seek for an alternative way to satisfy their need. The confessional booth is such an alternative, and in the past it was almost the only alternative available. With time, several other options were developed as platforms for sharing: first the telephone, then the internet (Facebook, Twitter and Instagram). It seems that nowadays the need to share is on the rise and the platforms that facilitate it are on the rise too.

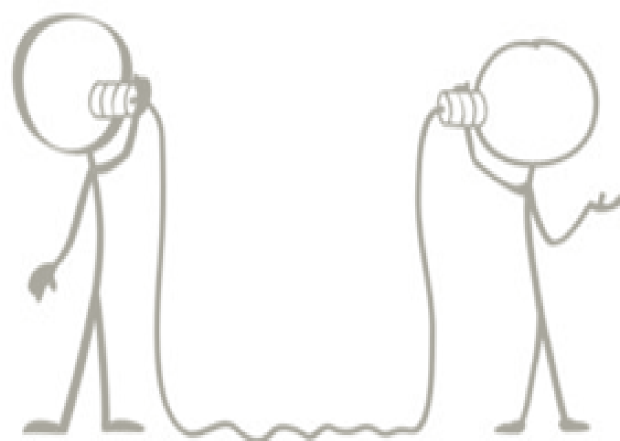
Lester and Rogers (2012) suggest that telephone therapy has a unique value as a treatment dimension useful for particular client life-styles and problems. They believe that telephone therapy provides an added dimension of therapeutic service and deserves recognition as a special way to link certain people with a helping service. The helping service provided by most agencies reaches individuals who are moderately distressed but excludes others whose problems make it difficult for them to seek help. A telephone counseling service provides greater penetration into the community, for an individual is as close to a helping contact as he is to the nearest telephone.

This understanding is also described by Baker and Bufka (2011) who suggest that the psychologist community could relate to the topic of telephone interventions with greater assuredness and accept that it may enable them to reach more patients and provide therapy in a more efficient manner.

The summation can be found in the words of Williams and Doubs (2012, p.41): the telephone has unrealized potential as a therapeutic instrument which can reach many people who might otherwise not receive counseling. It is surprising that a profession whose essential tool is interpersonal communication has for so long ignored the possibilities offered by the telephone.

PART IV

The helpline



Chapter 6

NATAL's Longitudinal Interventions Model (LIM)

This part describes the NATAL helpline and the model it is based upon – the LIM – Longitudinal Intervention Model. This chapter presents the design of the helpline, and then the framework of the LIM is portrayed, according to its three main targets. Finally, the psychological approaches for interventions which structure the LIM are depicted. The next chapter will address the changes which were made in the LIM and the helpline over time.

The design of NATAL's helpline

'A designer knows he has achieved perfection not when there is nothing left to add, but when there is nothing left to take away'.

Antoine de Saint-Exupery

(De Saint-Exupéry, 2013)

During the design phase of NATAL's services, it was obvious that it is important to focus on forming the services offered to be as accessible as possible to the clients, due to the impact of the trauma/loss on their lives (Herman, 1994). Therefore, based on the awareness to the unique advantages of phone interventions, it was decided that the organization will offer a helpline. Its goal was to provide accessibility to the clients and to ease their way into NATAL's other services.

Furthermore, the newness of the organization, the originality of the subject matter (i.e. national trauma), and the rarity of such opportunity led to the creation of an innovative service – a helpline that offers a combination of phone interventions and therapeutic processes.

At the time, phone interventions were merely aimed at crisis intervention. This field had developed by then substantial practice based knowledge, yet drew a strict line between crisis interventions and psychological interventions or therapy.

It was unconventional, even bold, to structure the new NATAL helpline outside of the traditional conceptions and boundaries. To incorporate therapeutic ideas and practices in a non-clinical setting could even be perceived as unethical. Yet, it seems that innovation always stems from 'thinking outside the box' and rebelling against accepted dogmas: in this case, the desire to provide an

accessible and non-stigmatic service to traumatized individuals (i.e. helpline), while still maintaining professionalism and therapeutic goals.

To conclude, based on its well-known advantages, it was decided to offer a helpline as one of the main services of NATAL. Yet, it was also decided not to be restricted by conventional helplines limitations, in order to provide a broad and comprehensive solution for NATAL's clients.

Feedback from trauma and loss survivors, personal experience and intensive reading of scholarly literature led to an understanding that clients' needs are large and varied enormously – they cannot be met by a single intervention. That brought the idea of providing longitudinal intervention, which much like therapy will allow the opportunity to provide wider assistance.

Furthermore, although support is a crucial basic need of survivors, it is necessary to provide an additional element in order to help people recover, and not just grieve. Therefore, the unique model created for NATAL was developed with the intention to assist with improving the quality of life of survivors. Its aim was not merely supportive, but rather rehabilitating in its orientation.

This goal is far-reaching and considered to be not within the boundaries of helplines. Moreover, it is a characteristic of a therapeutic process and not of an intervention.

The unique reality at the time of the creation of the model enabled a process based on a "blanc canvas" – since the new model didn't have to be confined by the boundaries of phone interventions nor controlled by the strict rules of therapy, it could be formulated to follow new directions. The guidelines and practices of neither therapy nor phone interventions could have been applied completely to this model, thus there was a need to design a new framework that includes several elements from both.

The framework of the LIM

'Each man should frame life so that at some future hour fact and his dreaming meet'.

Victor Hugo

(Falkayn, 2001)

A presentation of a new model with its own characteristics and framework should include a description of rational and practical guidelines. Therefore, it is important to present an orderly operational model. This view represents the current trend in the domain of phone interventions - as Hutchison and Breckon (2011) maintained, organizations that develop and offer telephone counselling must adopt an intervention model and a stable and clear operational framework which enable supervision and assessment.

This model, developed in 1998, offers longitudinal phone intervention with therapeutic, consultative and supportive elements. The therapeutic attitude of the model was based on the approach presented by Rogers (1942, 1951), the "client-centered" approach. In terms of the subject matter, the model was based on Herman's (1994) work on trauma, combined with the work of Israeli researchers - Malkinson, Rubin and Vitztom (1993) on loss. The impact of Herman's (1994) work and Malkinson, Rubin and Vitztom (1993) work on the design of NATAL's model will be described alongside the model itself. However, the basis of this model relays heavily on Rogers (1942, 1951) and his core therapeutic conditions, to be described next.

Carl Ransom Rogers was an influential American psychologist and among the founders of the humanistic approach to psychology. Rogers (1942, 1951) developed the "client-centered" approach to counseling and psychotherapy, which became a backbone of therapists' repertoires. In his iconic book 'On Becoming a Person' he formulated a new conception - his main view was that the aim of therapy is to provide a facilitative psychological climate which will enable people to move towards the accomplishment of their inherent potential. The therapist should provide the core therapeutic conditions of unconditional positive regard, genuineness and empathic understanding (Thorne, 1991).

Rogers (1957) argued that the counsellor-client relationship is at the heart of the process, and that it is not about a repertoire of skills the therapist possess, rather it is about the therapist developing a

way of being. These therapeutic conditions of effective therapy operated independently of the therapeutic approach being used.

More than sixty years later, Kirschenbaum and Jourdan (2005) claim that the direction of much of the latest research on psychotherapy outcomes is consistent with Rogers's view that the core therapeutic conditions are indeed helpful with virtually all clients. These studies taken together suggest that therapists or counselors, who are accurately empathic, non-possessively warm in attitude, and genuine, are indeed effective. Also, these findings seem to hold with a wide variety of therapists and counselors, regardless of their training or theoretic orientation, and with a wide variety of clients or patients.

This newer research has gradually come to recognize and acknowledge, first, that the success of psychotherapy is only partly determined by the psychotherapy itself. Additional recognition of the newest generation of psychotherapy research is that the success of psychotherapy is not due primarily to the particular therapeutic approach. Rather, these approaches are roughly equivalent in their effectiveness. Bozarth, Zimring and Tausch (2001) said that the pervasive conclusion of decades of therapy research is that outcome is related to common factors rather than particular therapies - the common factors in effective psychotherapy have been characterized many different ways: therapist warmth, respect, empathy, acceptance and genuineness, positive relationship, and trust.

In summary, one may argue that based on Rogers's views, therapy can be provided by a warm, empathic, understanding, accepting and genuine person – whether he was trained as a therapist or not. This is a very unconventional view, which might even be dangerous because it doesn't consider regulation of therapy. Yet, it is one of the pillars of the new model described here – it is our belief that the goal of the longitudinal phone intervention is to provide a facilitative psychological climate which will enable trauma/loss survivors to process what happened to them, to grieve their loss and then to move forward with their life aiming at post-traumatic growth.

It is also believed that this intervention can be carried by phone specialists – people who possess certain therapeutic traits (e.g. warmth, genuineness), and are trained to provide the core therapeutic conditions specified by Rogers (1957).

Judith Lewis Herman is a psychiatrist, researcher, teacher, and author who has focused on the understanding and treatment of traumatic stress.

Herman is Professor of clinical psychiatry at Harvard University Medical School and Director of Training at the Victims of Violence Program in the Department of Psychiatry at the Cambridge Health Alliance in Cambridge, Massachusetts.

In her iconic book, 'Trauma and recovery', Herman (1994) set out a three-stage sequence of trauma treatment and recovery. The first stage involves regaining a sense of safety, whether through a therapeutic relationship, medication, relaxation exercises or a combination of all three.

This stage is aimed at getting a ‘road map’ of the healing process, setting treatment goals and learning about helpful approaches to reaching those goals, establishing safety and stability in one’s body, one’s relationships, and the rest of one’s life, tapping into and developing one’s own inner strengths, and any other potentially available resources for healing, learning how to regulate one’s emotions and manage symptoms that cause suffering or make one feel unsafe, and finally developing and strengthening skills for managing painful and unwanted experiences, and minimizing unhelpful responses to them.

The second stage involves active work upon the trauma, fostered by that secure base, and employing any of a range of psychological techniques. This stage of recovery and treatment is often referred to as ‘remembrance and mourning.’ The main work of stage two involves reviewing and/or discussing memories to lessen their emotional intensity, and/or to revise their meanings for one’s life and identity, and working through grief about unwanted or abusive experiences and their negative effects on one’s life.

The final stage is represented by an advance to a new post-traumatic life, possibly broadened by the experience of surviving the trauma and all it involved. This stage of recovery focuses on reconnecting with people, meaningful activities, and other aspects of life.

Simon Shimshon Rubin is a clinical psychologist and a professor in the University of Haifa. He is the founder and head of the International Center for the Study of Loss, Bereavement & Human Resilience. Rubin developed the Two-Track Model of Bereavement (Rubin, 1981, 1990, 1992). He presented an approach that focuses on both the functional and relational aspects of the response to loss. It emphasizes the continuing relationship to the deceased, while remaining attentive to the indicators of functioning that are disrupted.

The Two-Track Model of Bereavement includes the following main features. First, there is an understanding that bereavement response occurs along two main axes, each of which is multidimensional. The first axis is reflected in how people function naturally and how this functioning is affected by the cataclysmic life experience that loss may entail. The second axis, however, is concerned with how people are involved in maintaining and changing their relationships to the deceased.

This model challenges the popular view that the response to loss is rooted in the way individuals are perceived to function. The predominance of the focus on functioning is a concern because as long as functioning is overwhelmingly dominant, serious disturbances in the nature of the ongoing relationship to the deceased will continue to escape attention. This has potentially negative consequences on the mental and physical health of the bereaved populations. Therefore, this model suggests that it is necessary to look beyond the level of functioning following death as an attempt to further the ability to intervene following loss and mourning (Rubin, 1981, 1990, 1992).

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Eliezer Witztum, MD, is a professor in the Division of Psychiatry, Faculty of Health Sciences in the Ben-Gurion University and Director of Psychotherapy Supervision, at the Mental Health Center, Beer Sheva. He is also the editor of the Israel Journal Psychotherapy.

These three Israeli professionals dedicated their work to loss and bereavement. They published many articles and books presenting theory and practice – many of them focusing on bereaved parents of soldiers in Israel.

Two of their current publications working together were published in 2011 and 2012: 'The Two-Track Model of Bereavement: The double helix of research and clinical practice' and 'Military bereavement and combat trauma'. Their work focuses on the nature of bereavement's impact on individuals, the meaning of recovery and resolution in the years following the death, and the ways in which to conceptualize an adaptive and a maladaptive ongoing relationship to the deceased.

These scholars question the tendency of most clinicians treating the bereaved, who are primarily concerned with depression and functioning difficulties. They believe that the continuing relationship to the deceased is a critically important feature of assessment and intervention with bereaved. Yet, the importance of this feature is not self-evident to many clinicians, physicians and researchers.

They see *recovery* as the outcome of loss which needs to be examined along the dimension of functioning. Yet determine that it is as crucial to also reach *resolution* which is the more precise term for the dimension of the continuing relationship to the deceased.

Resolution refers to the symptoms that compose the complicated grief which are mainly preoccupation thoughts with the deceased, yearning and searching, feelings of disbelief and being stunned by the loss. The goal of *resolution* of the loss is that memories and thoughts will be available in a balanced fashion and provide a measure of strength, warmth, and solidity to the core experience of the bereaved (Rubin, Malkinson & Witztum, 2011; Rubin, Malkinson & Witztum, 2012).

The LIM - key targets

'When it is obvious that the goals cannot be reached, don't adjust the goals, adjust the action steps'.

Confucius

(Fingarette, 1998)

Based on Herman's (1994) work and the work of Malkinson et al. (1993), the longitudinal intervention model (LIM) sets three key targets for the recovery or rehabilitation process: first, generating confidence and trust, then assisting the telling of the story of the trauma/loss, and finally promoting the reestablishment of the relationships between victims and their communities.

Target 1: Generating confidence and trust

'The best way to find out if you can trust somebody is to trust them'.

Ernest Hemingway

(Baker, 2003)

There is a consensus among therapists that the first requirement of psychological work is to create a safe place (Ayalon & Lahad, 2001). This was defined by Winnicott (1965) who said that the therapy situation should become a "holding environment" which is a safe place for the client.

As described by Herman (1994), the basic trust (Erikson, 1960) of trauma survivors shatters due to fear/terror, resulting in alienation and detachment from family and community.

Erikson (1960) has described trust as the cornerstone of the vital personality. He proposed that the task of the therapist is to 'convince individuals that they can trust us to trust them so they can trust themselves'.

Therefore, the first task directly following trauma or loss is to rebuild minimal trust: The victims are acutely aware of the frailty of all human bonds in the face of danger, and so they require a clear

promise that they will not be left alone (Herman, 1994). The paradox lies in that the traumatic experience leaves the person alone, unable to trust themselves or others, while on the other hand, needing others (Grand, 2000; Keinan, 2012).

Callers to NATAL's helpline use this medium because it allows them to 'test the water' without risking themselves. Unable to trust others, they make the initial call, maintaining control and testing the service to check if it is reliable. It is clear, then, that the first and main task of the service is to prove it is trustworthy.

At the NATAL helpline generating confidence and trust for callers is achieved by taking three steps, described below.

A. Creating a safe, stable and enduring space

Like infants, troubled individuals need to feel safe before they can explore (Rogers, 1961). Therefore, as Young, Klosko and Weishaar (2003) said, therapists seek to create a situation that provides safety, stability and acceptance.

In the safe place the patient is affirmed and the expression of needs, desires, and feelings is encouraged (Ayalon & Lahad, 2001). This is compatible to the view of Rogers (1961) that trust can be defined as a state of being; in which people believe that their needs can be met without injury by others or their environment.

The LIM aims at creating a clear/transparent structure in which the connection between the caller and the helpline is maintained by the same person, at a fixed and predetermined day and time. This generates stability and permanence for the object of communication and nurtures the caller's sense of confidence.

By describing this setting to the callers, in the beginning of the relationship, it is possible to help them understand what they can expect from the helpline. Yet, generating trust and confidence isn't that easy.

At first, callers don't trust the helpline or the specialist. They are told that the specialist will call them every week, but they consider it to be an empty promise. It takes at least a month of proven constant calls from the specialist before they start trusting this promise. These weekly calls create stability and consistency for the caller. Once callers are convinced that the specialist will continue to call every week, they start believing that the specialist is reliable, and then they are able to trust the specialist himself/herself. The stable and enduring space, therefore, leads to the creation of confidence (Havens, 1996).

This developing trust and the rapport which is built between the specialist and the caller enable callers to gradually allow intimacy and sharing. Consequently, they become the helpline's clients, i.e. they engage and commit to the therapeutic process at the helpline.

As the sharing is growing, the clients start anticipating the specialist's calls and become more and more aware of what they are getting through these conversations (e.g. 'I wanted your advice and support'). When the specialist shows empathy, understanding and acceptance, then the clients also feel safe (Rogers, 1957; Havens, 1996).

B. Setting clear and defined boundaries

In order to create trust and a sense of confidence in the caller, the telephone relationship with NATAL is based on a setting (structured situation) with defined features.

It was Freud (1912) who first suggested what is known as the therapeutic setting - these are the 'rules of the game', the ritualized arrangements concerning the matter of the length of the treatment session, the therapist's affective responses, the different roles, neutrality etc. Today, the therapeutic setting is well-accepted by clinicians and considered as a key element in all forms and approaches of therapy. This contemporary consensus is reflected by Wang’s (2000) view, that clear definitions and structures provide a framework in which the therapeutic process takes place. This framework determines the setting of times, behaviors, roles and boundaries – thus advancing the entire process.

Modell (1991) defines boundary as the border between everyday life and the frame that contains the treatment. Therefore, it is clear that framework/setting with boundaries should be a key characteristic of any therapeutic process.

Setting boundaries for both the caller and the helper are required, especially due to the absence of physical limits for the telephone conversation. There is need to provide a psychological space for working on the one hand and protecting the caller on the other hand. Therefore, the specialist is responsible to set, describe and preserve the clear boundaries determined for the LIM. It is the specialist's role to also describe and explain this setting and the boundaries to the caller.

The setting is structures by three main elements. The first and most crucial element is that the whole process at the helpline is with a specific specialist. Each caller is assigned a specialist that takes care of him from the beginning of relationship until the end of the helpline's intervention. Every conversation with the helpline will be done with the same specialist at the same day and hour.

This defined structure provides clarity and safety for the callers who learn after a while that they can trust the structure and the specialist. This element of the setting is usually well-accepted and appreciated by the callers, unlike the other two elements.

The second element of the setting limits the frequency of conversations to once a week. The caller cannot talk with the specialist more than once a week – this is in order to prevent the development of dependency on the helpline or the specialist.

The third element of the setting determines that the conversation shall last no longer than 20-30 minutes. Additionally, there shall be an emphasis placed on abstaining from opening up too many issues during a conversation. These limitations should be managed and observed by the specialist in order to protect the caller from experiencing emotional flooding.

At first, some clients don't like or appreciate the setting and its boundaries. Some of them resist and try to test or challenge the boundaries/specialist (e.g. calling more than once a week, asking for longer conversations). This resistance to the setting and negotiation with the specialist is a well-known phenomenon, documented and described by many mental health professionals who believe that commonly, patients gradually discover the nature of the therapeutic relationship through testing of the therapist (Modell, 1991; Eisenstein, Levy & Marmor, 1994).

It is important at that stage to firmly guard the setting, as it is in the best interest of the client. This is done by reminding the clients that the specialist calls every week and they can trust that there will always be another conversation in which they will be able to talk about whatever they want and didn't get the chance to do in the last conversation. They are also given an explanation of the specialist's role to protect them and keeping them safe – therefore "dosing" the arousal during the conversation must be determined by the specialist in order to assure the client's well-being.

After a while, there comes a time, when clients not only trust and respect the setting – they also acknowledge its benefits, particularly the opportunity to participate in an ongoing, gradual and safe process.

Reaching out to callers

Reaching out is a proactive approach in which the mental health professional initiates contact and change rather than waiting for them to occur (Boyd-Franklin & Bry, 2012).

Ingram et al. (2008) claim that the discrepancies between those who need help versus those who receive professional treatment are evident all over the world. This begs the general question of how to attract those people who are in need of help but are either resistant to seek out assistance or do not know where to obtain help. One option is to widen the array of available avenues to mental health services.

Similarly, Cupitt (2009) said that reaching out is a means of helping people with serious and persistent mental health difficulties who have not engaged with conventional mental-health services. It is based on the application of psychological approaches - a process which involves forming new relationships and offering hope to people who have been alienated from traditional methods.

Moreover, Cupitt (2009) describes the clients as people who dislike mental health services, are alienated from wider society and struggle alone – a description that is similar to the description of many of the people suffering from PTSD or loss.

Many theoreticians found that the main ramification of trauma on victims is regressing to a more primitive psychological functioning (Davenson, 2004; Schellekes & Dekel, 2001). Based on this finding and in light of the lack of energy which characterizes the victims, it seems that reaching out may enable people to receive the service they need yet unable to attain.

Additionally, survivors of trauma and loss tend to break their human ties - from close family relations to their community (Herman, 1994; Schellekes & Dekel, 2001). Many of them feel that people don't understand their suffering and resent the attempts to 'send' them to receive professional mental health assistance. The likelihood that these people will voluntarily seek help is very slim.

Therefore, reaching-out to these people seems like a good and flexible solution to their problem, yet conventional psychotherapeutic ethics usually determine that the client should seek help and that no one can be helped unless they are motivated enough to instigate a contact to the therapist (Bond, Witheridge, Dincin, & Wasmer, 1991).

In consideration of this complex situation, the NATAL helpline offers a somewhat less-traditional approach: any person seeking help (related to trauma/loss) is invited to call the helpline. This intentional first step is crucial to the future because it is a declaration of that person saying "(1) I have a problem, (2) I can't deal with the problem on my own, and (3) please help me".

As Kessler, Brown and Broman (1981) suggest, voluntary contact with a formal helper will take place only if the individual (1) comes to recognize that he/she is suffering from an emotional problem and (2) thinks that psychologic help is needed to handle the problem.

Acknowledging the existence of a problem and the understanding that one needs help in coping with the problem are the first phase in the therapeutic process, without which change cannot happen (Campos, 2009).

Yet, the understanding that this population is vulnerable and needier (temporarily and as a result of the trauma/loss) leads to a more unique characteristic of this helpline model. This uniqueness is manifested by a protocol according which after the first contact with the helpline (made by the caller); the following contacts are made by the specialist. The setting according to this model is that the specialist reaches-out to the client every week.

This is a non-traditional and proactive role of the helper which stems from the belief that survivors of trauma and loss are detached and disconnected from human relations and from society and that it is the society's responsibility to reach-out to them.

Many times callers to the helpline are relatives of the survivors that see their predicament and wish to enlist someone to help them. It is natural and understandable, yet cannot be fulfilled by the helpline. In such cases, the callers are guided by the helpline staff how they can encourage their relatives to contact the helpline. They are also offered to receive help themselves at the helpline until the time is right for their relatives to seek help.

To conclude, Stein and Santos (1998) say that reaching out is a flexible and creative client-centered approach to engaging service users in a practical delivery of a wide range of services to meet complex health and social needs and wants. It is a strategy that requires the service providers to take an active role. Similarly, this model considers both the need for survivors to take the initiative and accountability for their mental health, and also the need for consideration to their difficulties and limitations. Therefore this setting is designed to balance these contradictory needs to enable traumatized people receive the help they need but seldom ask for.

It is important to emphasize that the setting of this model provides the element of reaching-out not just as a mean to enable better accessibility to the service. The goal is much larger and more profound than that.

Considering the devastating effect of trauma/loss on victims' basic trust, as described by Herman (1994), NATAL's helpline model attempts to achieve more than providing mental health services to reluctant people – the intention is to provide clients with an experience of caring and showing of interest, which is central to creating trust.

This view is also suggested by Cupitt (2009) and Bond et al. (1991) who claim that the primary task of reaching-out is to build a supportive relationship which can offer hope to people who have often become alienated and disenfranchised.

The experience at the NATAL helpline shows that the element of reaching-out is indeed highly contributing to the creation of a supportive relationship with the callers. Callers are impressed and touched by the weekly call they receive from the specialist. They feel that there is someone who remembers them and doesn't forget to call them, and that someone cares about them and calls to ask about their situation and well-being. This is the way for the specialist to show care for the client and generate trust between them. It creates the foundations of a safe and trustworthy space for the therapeutic process to develop and bloom.

Target 2: Retelling the story of the trauma / processing the story of mourning

'There is no greater agony than bearing an untold story inside you'.

Maya Angelou

(Angelou, 2013)

In psychotherapy practice, clients have always been encouraged to tell their stories (Romanoff, 2001). Therapists recognize that humans shape experience through narrative meaning, therefore the telling of the story per se has been recognized as having therapeutic value in and of itself (Neimeyer, 1995).

The importance of providing people with a space where they can tell their story is well-recognized in the field of mental health. Duncan and Miller (2000) describe this process saying that therapy begins by inviting clients to tell their stories (i.e. "what brings you here today?"). In the course of telling their stories, clients unfold their experiences, their philosophies of life, and their reasons for living— or not wanting to. Clients are novelists who carefully choose words to convey their story in a specific light.

As fundamental as the story-telling is in the therapeutic process, it seems that after a trauma/loss it is even crucial to encourage clients to tell their story: Herman (1994) claims that regarding the

rehabilitation process, it has been reported that the recalling and telling of terrifying events as they occurred is a precondition for healing the lone victim and for reestablishing social order.

This view is also expressed by Cyrulnik (2009): "The ability to translate the images they have seen and the commotions they have experienced into words and verbal presentations that can be shared, so as to give them a meaning that can be communicated restores their humanity".

However, many victims sense that their close environment cannot contain their story of trauma: The traumatic experience floods them with intense emotions which threaten the victim and their environment. Grand (2000) and Silverman (1986) believe that at the heart of the traumatic experience there is a region of experience that cannot be shared, in which catastrophic solitude exists and therefore victims cannot share their experience with others.

Similarly, Bonanno and Kaltman (1999) found that there is growing evidence that the repeated communication of intense negative states, such as sadness or distress, may overwhelm and, in some instances, actually drive away people in the social environment who might otherwise offer interpersonal support.

Since this traumatic experience is so unsettling and exceptional, the victims feel that others would not understand it, and therefore keep their personal story a secret.

To conclude, there are several important goals to encouraging clients to tell the story of their trauma, starting with the provision of a space to share and create intimacy by self-disclosure, promotion of self-exploration in a safe environment, processing difficult events and feelings, and finally making meaning of the traumatic experience. It is unnecessary to mention that all of the above require the presence of another human being, who is an understanding person, empathic and compassionate. As described by Harvey, Carlson, Huff, and Green (2001), the meaning maker must have confidence in the confidant's ability to listen and care and be a dependable, discreet friend.

The helpline model offers opportunity and encourages clients to tell the stories of their trauma. Some callers tell their stories uninhibitedly, specifying horrific details and describing it as though it happened to someone else. They are emotionally disconnected to the event and are focusing on facts and details. These callers also try to tell their stories to people around them, family and friends, who are unable and unwilling to listen to those gruesome descriptions, which makes the survivors feeling unaccepted and worsen their shame and guilt. For these callers, the helpline is the only place where they can share their experience and still feel comfortable, understood and accepted.

With this type of callers the goal of the specialist is to help them form a story that will include not only the details but also the emotions and meaning. Another important goal is to show them how they

can share their stories with others in a way that will not be overwhelming or intimidating. This will eventually help them to re-connect to their natural support system and will lead to more positive feelings of acceptance and belonging.

The second type of callers is the ones who have difficulty telling their stories. They either don't remember some parts of the event, or they didn't tell themselves the story – being afraid of the devastation associated with the horrible experience of the trauma. Being so reluctant to tell the story, they can't share it with no one – not their family and friends and not with the helpline. The story, as well as the experience is frozen in a way, unreachable and therefore unchangeable.

With this type of callers the goal of the specialist is to help them start forming and telling their stories, first to the specialist and later to their family and friends. In these cases, the story is slowly and gradually formed, while the client is working on searching the missing/forgotten pieces and weaving them to a coherent and organized narrative.

Calhoun and Tedeschi (2001) refer to this therapeutic process and suggest that it is crucial in working with trauma survivors to listen closely and as comfortably as possible to horrific stories. Although it may be tempting to try to comfort, solve, or be quite sympathetic, it is important to support clients in the struggle, not to short circuit the constructive processing of trauma.

To conclude, for both types of callers, the telling of the story has two main therapeutic purposes: first, to ease client's loneliness and isolation (due to their inability to share their story). Second, to promote a processing of the traumatic experience that will enable the client to reconcile and come to terms with the event and its implications on their lives (making meaning).

From a trauma perspective, verbal disclosure promotes integration and cognitive restructuring of the more difficult aspects of the loss, as well as the exploration of more efficacious possible selves, and fosters the self-regulation of distressing emotions and bodily reactions (Greenberg, Wortman & Stone, 1996; Pennebaker, 1989; van der Kolk, 1994, 1996; Bonanno & Kaltman, 1999).

Yet, many victims, wishing to protect their close ones or maintain their perceived image and status, do not share their personal stories with others. As a stranger, the phone specialist allows the caller to share their difficult feelings and their weaknesses without the need to maintain a façade (Tamir & Haimov, 2005).

In the context of mourning, Davenson (2004) found that speech is a symbolic and perceptive way to 'stay close' to a lost close one. 'Talking about it' is a cure for mourners, and it is still one of the best ways to dampen the experience of separation.

Much like traumatized individuals, the bereaved often feel that there is disconnect between the past and the present - that their former lives, as it was, are over. Similarly, Calhoun and Tedeschi (2001)

suggest that the individual’s life narrative can become divided into “before” and “after” the loss/trauma.

Therefore, Keinan (2012) suggests that recovering from war or terror attack requires overcoming difficult memories: to cope with loss and reconnect the pieces of life from before the incident with those that came after it.

Continuity is an important psychological factor, and accordingly Neimeyer et al. (2010) found that the bereaved and the therapist struggle to meaningfully integrate the loss into the survivor’s life narrative, in a way that establishes a thread of consistency and significance in the midst of a turbulent transition.

The consensus that seems to be emerging among scholars and clinicians is that the purpose or goal of grief is the construction of a “durable biography,” a narrative story that organizes and makes meaning of the survivor’s life after the death as well as of the life of the person who died. The process by which this is achieved is active interaction within a community in which the death is recognized, the deceased person is mourned, and the continuing bond with the dead person is validated and shared (Klass, 2001).

This view introduces another important aspect of the grieving process, which is the presence and involvement of others. Similarly, Attig (2001) suggests that we grieve individually and collectively in complex and interdependent interactions with others.

The interaction with the specialist at the helpline provide the callers with the opportunity to grieve in the presence and involvement of someone who is empathic yet distant enough to allow them focus on themselves without the need to consider the specialist's feelings or comfort. Callers who cannot share their feelings, thoughts and memories with their family and friends, can find such a place with the specialist at the helpline.

The need to tell the story and share it with others can also be found in Harvey et al. (2001), who claim that those who had lost close others to death struggle to reframe the sense of bond and make it a sense of embracing the memory of the lost other. This reframing involves a commitment to telling and retelling a story of loss and recognition of the value of “owning one’s losses” as significant parts of one’s regularly changing identities. They need to confide in others and share their stories.

Also, Nadeau (2001) found that families use meaning-making strategies interactively to make sense of their loss. The most commonly used strategy is storytelling. As to the helper/therapist's role, she says that working with grieving families consists, first of all, of hearing their stories in the most intricate detail. Help consists of listening for meanings, clarifying that which is not clear and verifying meanings. Support for emotional reactions needs to be congruent with what the death means to the family (Nadeau, 2001).

Therefore, the specialist's role is to create a facilitative context for their client's mourning in which they could securely engage with them in the exploration and elaboration of the continuing meaning of their dead loved ones. Hagman (2001) suggests that rather than viewing the therapists as a catalyst of the mourning process, the therapist should play an active, even central role in facilitating mourning. The therapist role is to be interested in the meaning of the relationship to the deceased person.

In summation, Harvey et al. (2001) maintain that a confidant is critical for meaning making to be an effective means of coping. Therefore, one of the main roles of the helpline therapist is to serve as a confidant and allow survivors of trauma/loss to tell their stories safely and to a trustworthy person. Moreover, as Herman (2003) says: victims need an opportunity to tell their stories in their own way, in a setting of their choice – this is what NATAL's helpline is there to provide.

Target 3: Reestablishing relationships between victims and their communities

'No man is an island, entire of itself; every man is a piece of the continent, a part of the main'.

John Donne

(Donne, 1988)

Most of the callers to the helpline report having significant difficulties, as a result of the trauma/loss, in their relationships with others; their family, friends, colleagues, neighbors or others. The helpline model emphasizes the important role of the specialist to help callers reconnect to people around them.

Loss and trauma are personal and individual matters. Yet, it cannot be ignored that such happenings have an impact on larger environment, and the individuals involved are affected by their surroundings.

In Freud's view (1912), grieving was primarily a private or intrapsychic process (Bonanno & Kaltman, 1999). Today, scholars suggest that both intrapersonal and interpersonal aspects of loss are part of the grieving process (Rubin, 1981, 1999).

The connection between the private and personal process to the wider setting is demonstrated by Malkinson, Rubin and Witztum (2000) who found that death and the grief which follows it is an

individual event that takes place within a specific context for which society has developed a set of rules and norms.

Field experience suggests that these norms aren't explicit and overt and therefore many times survivors feel they need to cope with ambiguous situations when they are unsure of what is expected of them. This confusion and awkwardness combined with the blow of the loss/trauma may have serious consequences.

Calhoun and Tedeschi (2001) maintain that individuals report a worsening or breaking of social bonds in the struggle with loss. Attig (2001) also refers to that saying that when people grieve they are challenged within their most intimate relationships and they are challenged in relationships with casual acquaintances and work colleagues.

An explanation of this phenomenon is provided by several scholars. Rubin (1993) claims that the death of a close person damages social inter-personal structure because interpersonal relationships may seem meaningless to the bereaved. Additionally, Keinan (2012) suggests that often, people who experienced trauma or loss wish to isolate themselves and disconnect from others, and as a result, intimacy with the family unit and the social environment is ruined.

Similarly, in the context of trauma, Sewell and Williams (2001) maintain that it has long been known that social functioning is disrupted in traumatized individuals. Herman (1994) also found that trauma breaks the bond between individuals and their communities, leaving them isolated.

However, coping with loss and bereavement requires human connection and closeness. The essence of coping is the effort to 'reconnect' life.

Attig (2001) presents a graphic description of the relationships between victims and their communities. He says that families, communities, and all of humankind are joined as webs of webs. Bereavement and trauma strike a blow to those webs; therefore the recovery process is reweaving the fabric of life in order to come to a new wholeness.

The shared view in this field can be summed by Herman's (2003) conclusion that victims need social acknowledgment and support. The reason for that can be found in Attig's (2001) words, saying that socially, we reconfigure our interactions with others. Interactions with others profoundly affect our individual relearning. And, together with others, we reshape and redirect our family and community life patterns and life histories.

Many of the helpline callers are disconnected from their past relationships that were damaged by the trauma/loss. The belief that guides the helpline work is that their initial phone call to the helpline is in fact the first step towards reconnecting to others. The goal is to first generate trust (first target of the LIM), then to build a stable interpersonal relationship between the caller and the

specialist, and then rely on this new connection to serve as a model and affirmation of the possibility to reconnect or build familial and social ties.

The recovery after loss occurs for many when they are able to reconnect with family, friends old and new, and their community (Frantz, Farrell & Trolley, 2001). Similarly, Davenson (2004) suggests that a supportive community of friends does much towards dulling the pain of separation. Therefore, sometimes the best therapy is to build new relationships.

Herman (1994) also maintained that in order to heal from trauma, a renewal of the connection between victims and their communities is required–sharing with others the traumatic experience is a precondition for regaining the feeling that the world has meaning. During this process, the victims require assistance from their close ones as well as from the wider community.

This social need of survivors is explained by Nadeau (2001) who says that individuals do not grieve in a vacuum. They make sense of their experience by interacting with others. Attig (2001) adds to that saying that when we grieve we must also relearn our social surroundings.

Therefore, the specialist role is to serve as a practice tool for callers to relearn and re-experience interacting and sharing with people around them. The specialist is specifically instructed to not only inquire about the presence of family and friends, but also actively show clients opportunities of reconnecting to their social surroundings and to assist them strengthen their natural support system.

The specialist's role is to prove to clients that it is possible to interact, talk and share the difficult experiences with others. As mentioned by Bonanno and Kaltman (1999), there is a social need to talk with others about particularly difficult or traumatic losses.

Similarly, Harvey et al. (2001) emphasize the importance of the public social interaction, claiming that the social interaction part of the process is as crucial as the act of creating and working on a story. The individual needs to confide part of his or her story to close others over time in order to assimilate different major stressors and losses.

Cyrulnik (2009) even takes it one step further saying that the way families and the cultural environment talk about wounds can either attenuate or exacerbate that suffering, depending upon the stories they tell.

All these scholars emphasize the fact that victims need social interactions, acknowledgment and support, since the ground for recovery is based on human ties.

In regards to the Israeli experience of coping with national trauma, research has shown that family and the immediate social surrounding can serve as a buffer against the emotional impact of terrorist attacks. Henrich and Shahar (2008) demonstrated that social support of friends and family buffered the effect of exposure to rocket attacks (Dechesne, 2012).

Similarly, Updegraff et al. (2008) found that in collective upheavals, the meanings people find may be far more likely to be constructed in a social context. In fact, some people dealing with adversity report an increased appreciation of supportive social ties.

Therefore, people who seek practical assistance from others may be best able to find meaning, which helps their coping.

In relation to this, Keinan (2012) mentioned that the national context imbues much importance to the response from society: Since the damage stems from belonging to society, the victims' healing processes are closely related with social recognition of the heavy burden that they carried for the benefit of others.

NATAL, a nonprofit and non-governmental organization (NGO) and its open helpline and volunteers constitute part of the community to which the victim belongs to, and the latter's ability to make use of the former is an initial step towards renewing their connection with society. In that sense NATAL serves two almost contradictory purposes: on the one hand it is not considered as part of formal state's establishment and therefore can function as a bridge between the individual and society. On the other hand, NATAL's philanthropy, voluntarism and its agenda of treating national trauma enable victims to feel they get the social recognition they long for.

The specialist at the helpline obviously belongs to the same community of the callers. Many times they have similar struggles, especially dealing with the problematic security situation. Therefore, it is possible to demonstrate this connection to clients, thus creating the first link in the chain that connects us all to family, community and society.

Each of the three key targets of the LIM; generating confidence and trust, assisting the telling of the story of the trauma/loss, and promoting the reestablishment of the relationships between victims and their communities – is a crucial element in the recovery process. The helpline specialists are guided to work on all three targets, sometimes one after the other and at other times, simultaneously. Yet, it is needless to say, that the first target is always the basis for future work, and without the trust and confidence of the clients nothing else can be achieved.

Similarly, since this model aims at recovery and rehabilitation, the other two targets must also be pursued.

The LIM - psychological approaches for interventions

'I believe that a different therapy must be constructed for each patient because each has a unique story'.

Irvin D. Yalom

(Yalom, 1996)

After presenting the theoretical background and rational of the LIM, and depicting the key targets and the way to achieve them, it is also important to describe the psychological approaches which lead the helpline activity and interventions.

The LIM is an eclectic one. Eclecticism is a term that comes from Greek and refers to a conceptual approach that does not hold to a single paradigm, but instead draws upon multiple theories, styles, or ideas to gain complementary insights into a subject, or applies different theories in particular cases (Liddell & Scott, 1996).

Eclectic psychology refers to a therapeutic approach in which a variety of methods, principles and philosophies are used to create a treatment program that caters to a patient's unique needs. Rather than adhering to a certain school of therapy, eclectic therapists use techniques from all schools to treat patients (Goldfried & Newman, 2005; Winston, 2006).

Studies (Garfield & Kurtz, 1977; Norcross & Prochaska, 1988; Goldfried & Newman, 2005; Norcross, Karpiak, & Lister, 2005) showed that mental health professionals define and use eclecticism in their work as pragmatically selecting whichever method best fits a particular client, combining several theories in therapy, and integrating a number of therapies.

Norcross et al. (2005) said that the most frequent combination of theories and therapies in the 1970s was psychoanalytic and behavioral, in the 1980s the most common combinations were cognitive and behavioral and then humanistic and cognitive.

Similarly, the LIM endorses a broader orientation of both subject-matters: therapy and phone interventions. This unique model is radically different in both philosophy and practice from psychotherapy and from helplines' interventions. From the perspective of therapy, the LIM combines elements from all the major psychological theories and approaches: dynamic, behavioral, cognitive, narrative and humanistic. It also draws from a spiritual approach – Buddhism.

Next is a portrayal of the way some of the approaches are used within the LIM.

As described earlier, the *humanistic approach* shaped many aspects of the LIM, mainly by its philosophy and worldview.

This approach is optimistic and focuses on noble human capacity to overcome hardship, pain and despair. According to this, therapy should provide an environment in which a person can foster growth and mobilize resources (Schneider, Pierson, & Bugental, 2014).

Humanistic psychology introduced the term 'self-actualization', which refers to psychological growth, fulfillment and satisfaction in life (Buhler, 1971; Colman, 2015). The humanistic approach sees self-actualization as a basic human motive which drives every individual to continuously enhance themselves (Rogers 1961).

In accordance to this approach, the helpline specialists are attempting to create a supportive atmosphere and relationship with the clients, so that it can help them to self-actualize.

The helpline clients are viewed as capable, resourceful and creative human beings, who are struggling to overcome a devastating event and need some assistance. In no way they are seen as patients suffering from an illness or as weak damaged people.

It is important to regard the helping process as a journey. The longitudinal phone intervention offers clients the opportunity to go through an in-depth process, where they experience challenges and breakthroughs. Such a process helps in self-discovery, which may have benefits for all aspects of life. Thus, this intervention intends to facilitate what is known as *post-traumatic growth* – as defined by Calhoun and Tedeschi (2001): the gains that can result from the struggle with loss/trauma, i.e. positive change that the individual experiences as a result of the struggle with a major loss or trauma.

The intervention is conducted by encouraging and promoting an introspective process, based on issues raised by the client. The clients' capability to reflect and comprehend their experience while being aware of their emotions, thoughts and contemplations may allow them to get out of their rut and begin to direct themselves towards a change (Gillespie & Meaden, 2010).

Frantz et al. (2001) even found that for an overwhelming majority of grieving people positive things do result from death. Similar results were found by Helgeson, Reynolds, & Tomich (2006) and Poulin, et al. (2009) who studied the effects of trauma on Americans after 9/11.

Today, many scholars acknowledge post-traumatic growth, yet they recognize that post-traumatic growth doesn’t occur solely with individual strengths – usually it is a painful process of "awakening" or encouraging the resources of the individual, a process that may be supported and promoted by family, friends, spiritual leaders and mental health professionals (Schneider et al., 2014; Linley & Joseph, 2004; Seery, Holman & Silver, 2010). The LIM was design to stimulate, encourage and support post-traumatic growth.

The humanistic approach of the NATAL helpline also determines the relationship between the helpline specialist and the client.

This is a very different type of relationship to that of expert and client, in which dependent tendencies may be encouraged, causing the client to feel that the responsibility for changing or improving the situation lies in the hands of another (Buhler, 1971). Such a relationship may involve a degree of loss of self, which can reinforce past events and feelings of powerlessness experienced by trauma survivors (Lahad, 2001). In the person-centered approach, the therapist maintains a deep respect for the individual's ability to solve problems if given the opportunity. The responsibility to make choices and instigate change remains with the client who leads the way. It is a gradual process and recognized as such by the therapist (Rogers 1961).

Accordingly, the helpline specialists see themselves as companions on a journey rather than the expert guides. Their relationship with the helpline clients is characterized by mutuality, equality, trust and respect.

To conclude, Lahad (2001) found that the Person-centered approach is especially suited to trauma survivors because of its overriding emphasis on the establishment of a safe, trusting relationship.

Another approach used within the LIM is the *narrative approach*, which has some common characteristics with the humanistic approach.

Narrative therapy, as developed by Michael White and David Epston, is a collaborative and non-pathologizing approach to counselling which centers people as the experts of their own lives (White & Epston, 1989; Carr, 1998; Brown & Augusta-Scott, 2006).

The narrative approach views problems as separate from people and considers people as having many skills, abilities, values, commitments, beliefs and competencies that will assist them to change their relationship with the problems influencing their lives (White, 2004; Angus & Greenberg, 2011).

Narrative therapy is aimed at helping people to ‘re-author’ the stories of their lives. Moreover the focus is not on ‘experts’ solving problems. It is on people co-discovering through conversations, the hopeful, preferred, and previously unrecognized and hidden possibilities contained within themselves and unseen story-lines (White, 2011; Brown & Augusta-Scott, 2006).

The helpline specialist works with the client to co-author a new story about the trauma/loss and the client's coping with it. The focus of attention is towards the emphasis clients put on problems or negative aspects of their experience. The helpline specialist encourages the client to attend to the neglected more positive parts of their experiences, and helps them see new meaning in their experiences.

Also, the helpline specialists work with clients on *'Meaning making'*. This involves coming to see or understand the situation in a different way and reviewing and reforming one’s beliefs and goals in

order to regain consistency among them. The processes through which people reduce this discrepancy involve changing the appraised meaning of the situation (i.e., reappraisal) and changing their global beliefs (Cyrulnik, 2009).

The LIM also takes a *collaborative problem-solving orientation* in which specialists and staff attend to specific life issues of the clients. *Problem-solving therapy* refers to a psychological treatment that helps to teach clients to effectively manage the negative effects of stressful events (Chang, D'Zurilla, & Sanna, 2004). This is a cognitive-behavioral process in which one works to find adaptive ways of coping with everyday situations that are considered problematic (D'Zurilla & Nezu, 2010).

Problem-solving therapy can be designed and delivered as a multi-step process, which includes: defining the problem, brainstorming for solutions, decision making, and follow up stages (Areán et al., 2010; Chang et al., 2004). The LIM enables the helpline specialists to provide all of the above mentioned – they begin the process by working with the clients to select and define the problems which the client finds most bothersome or wishes to better cope with. Then, the specialist helps the client to learn effective coping skills in an array of stressful situations. The long-term relationship with the specialist and the helpline also enables follow-up to ensure the client continues using these techniques, finds ways to apply them to different situations in his/her everyday life and indeed feels that this approach was helpful for him/her in reducing emotional distress.

Also, it is important to note, that problem-solving therapy was shown to decrease psychological and emotional difficulties, to increase situational coping, as well as improve the quality of life of individuals (Chang et al., 2004; Malouff, Thorsteinsson, & Schutte, 2007; Areán et al., 2010).

Finally, although the LIM takes a collaborative problem-solving orientation – the model itself is by no means directed at solving problems, rather this is one of the approaches used to help clients.

The above description showed how some cognitive-behavioral approach and techniques are being used during the helpline interventions. Here is additional information of the applications of cognitive behavioral therapy at the NATAL helpline.

McLean and Foa (2011) maintain that cognitive behavioral therapy has been deemed the treatment approach of choice in clinical practice guidelines for PTSD by the American Psychiatric Association.

Bryant (2004) specifies the components that typically constitute CBT for PTSD, and said they include psychoeducation, symptom management, anxiety management, cognitive reconstructing, and exposure. Most of these components (with the exception of exposure) are part of the LIM.

Psychoeducation is usually the first and crucial step of an intervention following trauma or loss. Marsh and Johnson (1997) define psychoeducation as a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and educational interventions. It is based on strengths and focused on the present. The client and/or family are considered partners with the provider in treatment, on the premise that the more knowledgeable the care recipients and informal caregivers are, the more positive health-related outcomes will be for all (McFarlane, Dixon, Lukens, & Lucksted, 2003; Sherman, 2003).

Similarly, Kaltman and Bonanno (2003) suggest that educating clients that this is expected and consistent with research findings will enable the clients to accept their reactions and better understand their grief experiences.

The helpline specialists are specifically trained to provide psychoeducation, with the belief that this is a critical component of the intervention. The experience at the helpline shows that from the first conversation with the caller and onwards, it is beneficial to provide psychoeducation in most conversations. Scholars agree that psychoeducation is important in helping people understand their situation and learn coping techniques (Buwalda, Bouman & van Duijn, 2007). Yet, it has greater potential than that – the helpline experience shows that this is an important factor of the rapport building and trust generating processes. When the helpline specialist provides psychoeducation, it proves to the client that (a) the specialist is knowledgeable and therefore can be trusted as a competent helper, and (b) the specialist understands what the client is going through and therefore can be empathetic and compassionate.

All through the longitudinal intervention, the helpline specialists provide psychoeducational information which is relevant to the specific caller, the individual symptoms/behaviors discussed and the particular phase of the process. It is important to note that psychoeducation must be tailored-made to the client to be so effective and beneficial. When psychoeducation is provided in a general and routine manner it can produce the opposite undesired outcome.

Finally, psychoeducation is among the most effective of the evidence-based practices that have emerged and has broad potential for many forms of illnesses and varied life challenges. Lukens and McFarlane (2004) found that there is significant evidence that psychoeducational interventions are associated with improved functioning and quality of life, decreased symptomatology, and positive outcomes for both the person with illness and family members as well.

Another major component of CBT is *symptom management*, which is also an important part of the LIM.

Survivors of trauma and loss often suffer from different symptoms which have significant impact on their psyche, functioning and their quality of life (Lahad, 2000; Rubin et al., 2012; Herman, 1994; Ayalon & Lahad, 2001).

Yet, many mental health professionals believe that a breakdown in human functioning is not necessarily a disease to be medically treated but a temporary state whereby the individual’s coping capacities are insufficient or inadequate, resulting in a psychological disequilibrium (Lindemann, 1944; Caplan, 1964; Parad, 1966; Malkinson et al., 2000; Rubin, 2000).

Therefore, symptom management is aimed at assisting the individual to regain control and equilibrium.

Forbes et al. (2007) suggest that reducing the distress related to acute symptoms can free some of the client’s attentional energies, allowing more productive therapeutic work to be done in the other, reconstructive aspects of therapy.

Additionally, Kuhn et al. (2014) and Smith et al. (2007) maintain that the first step of symptom management involves an attempt to instill hope in the traumatized/bereaved client who feels his/her world or self to be irreparably lost or damaged. The most common mode of achieving this is to provide a personally meaningful rationale for why therapy might be useful in reducing the pain and disequilibrium following a traumatic experience or loss.

Similar to psychoeducation which was discussed earlier, symptom management efforts provide a compassionate vehicle for the therapist to join with the client in his or her struggle to deal with the pain and difficulty of adjusting to a trauma/loss. Thus, effective symptom management is a profound demonstration to the client that the therapist is taking the risk to see through his/her eyes, walk in their shoes, and share in the pain (Sewell & Williams, 2001).

The LIM views psychoeducation and symptom management as two complementary elements. Many times the intervention begins with the specialist asking the client to describe the symptoms bothering him/her. Then, based on the client's account, the specialist provides psychoeducation which focuses on the explanation of the presence and impact of the specific symptoms described. Only then the specialist can offer to teach the client some symptom management techniques to better cope with the situation. This form of intervention provides the helpline clients both a sense that their suffering and struggles are understood and also practical tools to help them deal with those suffering and struggles.

Sewell and Williams (2001) and Forbes et al. (2007) suggest that the specific techniques of symptom management are multitude. Some of the most quickly effective are the typically termed cognitive-behavioral techniques such as relaxation, breathing restraining, and grounding techniques (e.g. focusing on bodily sensations).

The LIM was designed with explicit attention to these techniques. The helpline specialists are trained to teach clients to use relaxation, breathing and grounding techniques. Moreover, an effort was made to prepare such teaching materials and tools so that the helpline specialists are able to send by post pamphlets and supplies (e.g. stress ball) with simple instructions for clients to practice these techniques at home, and also with the specialist during the phone conversation.

Among the materials developed at the helpline are: pamphlets and brochures teaching muscle relaxation techniques, breathing techniques, grounding techniques and guided imagery (e.g. 'safe place'). Also, supplies and tools to assist these techniques such as muscle relaxation balls, breathing balls and bubbles, biofeedback cards etc.

The LIM also allows for follow-up to make sure clients master the use of these techniques and find at least some of them to be helpful in managing their symptoms.

The approaches described thus far: the humanistic, narrative, behavioral and the cognitive demonstrate the eclectic and inclusive framework of the LIM. Perhaps the best example of this character is the use of the Buddhist approach at the helpline.

Mindfulness and teachings from Buddhism have been shown to alleviate a wide range of emotionally distressing conditions (Hölzel et al., 2011; Kabat-Zinn, 2011; Neimeyer & Young-Eisendrath, 2015).

Buddhist principles and practices carry clear relevance for treating bereavement (Cacciatore & Flint, 2012; Thompson, 2012) and other potentially traumatic life transitions (Ogden, 2010; Neimeyer & Young-Eisendrath, 2015).

Brazier (2007) suggests that Buddhist psychology has a distinctive, theoretical framework that offers some advantages in the conceptualization of traumatic change both from the perspectives of subjects and of therapists. The application of Buddhist method to such situations means helping the person to experience the traumatic shock as an opportunity, not merely a disaster.

The experience at the NATAL helpline shows that trauma and loss survivors struggle with the painful and sometimes seemingly meaningless reality of the trauma/loss. Such situations generate existential crisis which arises feelings of futility, hopelessness and devastation. At times like these, survivors cannot find comfort and people around them cannot find comforting words to offer them. Unfortunately, many times this will cause disconnect and detachment.

The helpline specialists are expected to provide comfort to clients, yet there are times and situations when they also struggle to find comforting words. This can drive them to be cold and disengaged or lead them to feel incompetent and desperate. The Buddhist approach can help them better cope with their feelings and their clients' feelings. It is important to emphasize that the Buddhist approach

is merely an example of the functional integration of spiritual activities with traditional therapy and crisis intervention, with the aim of reduction of human distress.

This approach of the LIM reflects the current view of scholars (Everly, 2000; Taylor, 2008; Bryant-Davis & Wong, 2013) who say that there has been a growing appreciation in the field of psychology of the central role that spiritual coping can play in the recovery process of trauma survivors.

To sum the different approaches presented here, it is possible to draw from Littleton et al. (2007) who suggest that there are two major coping strategies with trauma and loss. The first are *problem-focused coping strategies* - these strategies directly address the problem causing distress and include seeking information about the stressor, making a plan of action, and concentrating on the next step to manage or resolve the stressor. The second are *emotion-focused strategies* - these strategies focus on managing the emotional distress associated with the stressor and includes disengaging from emotions related to the stressor, seeking emotional support, and venting emotions. The LIM aims to help its clients to adopt both coping strategies, providing a therapeutic framework which allows for emotional support and processing alongside cognitive and behavior practical techniques.

After laying out the different approaches guiding the LIM, it is also important to detail the major steps and tasks of the helpline specialist.

Accomplishing the three key targets set by the LIM for the recovery or rehabilitation process is done by maintaining several elements. The specialist is instructed and supervised to perform/provide the following:

A. Create a connection, build trust and establish a therapeutic alliance.

B. Provide an empathic, attentive and containing experience, while sending a non-judgmental message, thus creating a sense of understanding of the caller.

C. Legitimize emotional expression not possible in other settings, attempting to ease the loneliness which characterizes people coping with trauma and loss.

D. Provide assistance with cognitive understanding of typical reactions and behaviors, and helping to cope with the question of life's purpose following trauma or loss.

E. Widen the range of interpretations and possibilities, including connecting to tools and strategies of coping.

F. Accompany the processing of the event, assisting the meaning-making while providing support at crossroads or stages of difficulty.

G. Support for the rehabilitation and rebuilding process of internal structures and external systems.

As a final point, the NATAL helpline can be defined as what scholars call *growth-oriented program* (Bond, 1991; Bond et al., 1991; Cupitt, 2001; Wright et al., 2003). Growth-oriented program aims at client growth and change through in vivo skill training and environmental modification. It also aims at addressing the comprehensive needs of clients in a holistic fashion.

The NATAL helpline is a service of a time-unlimited basis. It is characterized by a long-term commitment to clients, providing services for as long as their needs persist.

The helpline specialists work hand-in-hand with the clients, providing treatment, rehabilitation, psychosocial support, functional and practical help, and advocacy. All these are targeting the improvement of the quality of life for trauma and loss survivors.

This concurs with Corrigan, Mueser, Bond, Drake, & Solomon (2012) who suggested that significant trauma can interfere with life, leading to a need for rehabilitation. Rehabilitation refers to efforts to restore people with disabilities to optimal states of constructive ability. This process promotes recovery, reintegration into the home and community, and improved quality of life (Khan, Amatya & Hoffman, 2012; Pratt, Gill, Barrett, & Roberts, 2014).

In their review of empirical studies that documented positive change following trauma and adversity, Linley and Joseph (2004) have found that people with higher self-esteem and who were more optimistic tended to report more growth after traumatic events. Therefore, promoting post-traumatic growth should involve cultivation of clients' self-esteem, hope and optimism. It is an important role of the helpline specialist to encourage clients, strengthen their self-esteem and remind them that there is hope and change is possible – even when they cannot see it. The continuous relationship with the specialist, who calls every week, who doesn't despair or give up, creates a solid ground for clients – one that they can stand on safely before they start walking.

Another important element which influences post-traumatic growth is the provision of social support. Research shows that social support has been positively associated with reported growth after traumatic events (Park, Cohen, & Murch, 1996; Cadell, Regehr, & Hemsworth, 2003; Dunn, Occhipinti, Campbell, Ferguson, & Chambers, 2011; Cho & Park, 2013). Therefore, the LIM aims to serve as a source of social support for its clients, especially in the beginning of the intervention, when clients usually feel they don't have such support. At a later phase of the intervention, the goal is to help the client build or reconnect to other social support resources, which can be found in the clients' homes and/or community.

The unique roles of the helpline specialists, their warm and caring attitude, their continuous interest and encouragement – all these serve as a beacon of light in a sea of darkness. The helpline clients cherish this relationship (e.g. "you gave me my life back. I wish I could give you my life in return") and lean on it to help and guide them in their journey (e.g. "after I was able to tell you my story, I am ready to try and tell my wife").

To conclude, the LIM, relies on varied psychological and spiritual approaches, and is based on trauma/loss knowledge-based theoretical rationale, combined with experience-based practices. The backbone of the LIM is an integration of theoretical and practical elements drawn from the field of psychology with elements drawn from realm of phone interventions. This model attempts to provide an array of approaches aiming to create wide and varied perspectives for the treatment of trauma and loss. The opportunity to provide therapeutic interventions, without them being considered clinical by clients, lays heavily on the medium – the telephone.

Chapter 7

Changes over Time

'To improve is to change; to be perfect is to change often'.

Winston Churchill

(Churchill, 2013)

In the early days of the NATAL helpline, the LIM was a new idea which was based at the time on existing theory and practice. During the 17 years of its operation some changes occurred – in the professional world of phone interventions and also within the helpline as a result of the new experience accumulated during the day-to-day practice.

Change is the process of becoming or making different (Barker, 2003; Reber, 1995). Organizations, similar to individuals, are unlikely to survive and thrive without the ability to change and adapt to the challenges, opportunities, and threats they face (Ford, & Foster-Fishman, 2012). This is called *organizational change*, which is defined by Laszlo, Laszlo and Johnsen (2009) and Leonard, Lewis, Freedman and Passmore (2013) as both the process in which an organization changes its structure, strategies, operational methods, technologies, or organizational culture to affect change within the organization and the effects of these changes on the organization. Organizational change can be continuous or occur for distinct periods of time.

Margulies and Raia (1972) articulated some of the intentions of organizational change as seeking to increase the effectiveness of the organization in terms of all of its goals, and also providing opportunities for each organization member, as well as for the organization itself, to develop to their full potential.

Naturally, individuals and organizations change over time and develop. Development is defined as the process in which someone or something grows or changes and becomes more advanced (Hornby & Wehmeier, 1995). The LIM went through some changes over the course of time. Some of these changes were part of its natural growth process, and others were purposeful planned changes which occurred as a result of reflection, feedback and other external factors.

There have been small and minor changes, and also some significant changes in the LIM and the operation of the NATAL helpline. Next, two significant changes which had transformational effect will be described.

Challenges of the first conversation

'The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed'.

Carl Jung

(Jung, 2001)

Creating a guide specifying targets for the first call

In the early days of the helpline, specialists were trained to provide callers with reflective listening and active listening. *Reflective listening and active listening* are a communication technique used in therapy and counseling. It arose from Carl Rogers' school of client-centered therapy in counseling theory (DiMattia & Arndt, 1974; Fisher, 1984; Fisher, Merron, & Torbert, 1987). The listener is expected to fully concentrate, understand and respond to the speaker (Roberston, 2005). This strategy directs the counselor to attempt to reconstruct what the client is thinking and feeling and then to relay this understanding back to the client (Lang, Floyd, & Beine, 2000; Worthington & Fitch-Hauser, 2015).

The practical experience at the NATAL helpline suggests that this communication technique is found useful by the non-professional specialists, who report that it helps them to better understand callers and also help them convey interest and understanding of the callers. Positive feedback from callers may also suggest that this is a good strategy which helps to build rapport.

Several years after the beginning of the helpline operation, and as part of the continuous development of the professional model, it became clear that the specialists (especially those in training and the inexperienced ones) need additional techniques for the communication with first-time callers.

The first conversation with the helpline is very complex and complicated, for both the caller and the specialist. They don't know each other, they are guarded and careful, and therefore the communication doesn't flow. Yet, this first conversation is crucial to the assessment of the caller's situation, the reason for calling the helpline, the resources available and the ability of the specialist to provide assistance (in the present situation and in the long run). To this end it is essential to have clear and flowing communication. For that reason there was an attempt to develop a guide specifying targets for the first call.

In order to better understand the unique challenges characterizing the first helpline conversation, it is beneficial to start by describing the first conversation itself.

Description of a first call to the helpline

The incoming call starts with a greeting of the specialist who says: "Hello, Natal" (in Hebrew). This opening serves to identify the organization, and is also oriented to be a greeting of the caller. Specialists are advised not to automatically disclose their names. This has two reasons: the first is avoiding giving callers an impression of an obligation to provide their names, and rather to imply to the caller that should he/she chooses so, they can remain anonymous. After this opening the caller can then identify giving a first name, a full name or avoid giving a name at all.

Danby, Baker and Emmison (2005) said that a person who speaks first in a telephone conversation can choose their form of address, and thereby chooses the form of address the other uses. Therefore, the specialists are instructed not to directly ask for the caller's name at the beginning of the conversation, but rather wait for callers to disclose it voluntarily during the conversation – usually when they feel comfortable and safe enough.

The second reason for the specialist not to immediately disclose their name is that if they don't do that automatically at the beginning of the conversation, then they can use it as a playing card later on, encouraging reciprocity. In other words, during the conversation, when the specialist feels that the caller is more at ease and an initial rapport was built, they can then suggest that since they got to know each other a little bit better it might be helpful to disclose their private names.

In conclusion, from the very first moment, the helpline specialist is expected to indicate and demonstrate to the caller that they have optimal choice and complete control. The caller decides when and how much to disclose – they can 'test the water', test the helpline and the specialist until they feel safe enough. This is one of the advantages of helplines in general, but it is even more important when it concerns trauma victims – in such cases the difficulty to trust others is a characteristic of callers, which makes it crucial to allow them the time they need before they can trust the specialist. Moreover, usually during the traumatic event the victim feels helpless and powerless. The post-traumatic symptoms intensify these feelings. Therefore, allowing survivors/callers to be in control and power over their relationship with the helpline specialist, helps forming rapport and trust, and also support their recovery process.

After the initial introduction, the conversation flows, usually led by the caller (yet managed by the specialist), and can develop to several directions – the most common is the reason for calling.

In some cases, callers specifically say which reason made them call the helpline. More frequently it is something for the specialist to figure out during the conversation. There is an important distinction to be made between a ‘reason’ and a 'problem'. The specialist should search for the ‘reason’ for the call, and not for an identification of a ‘problem’ within the call. When it is unclear, the specialist can inquire as to what lead the caller to contact the helpline – phrased this way it is usually not intimidating nor making the caller feel bad because of his/her problem.

Since the desired message to the caller is that his/her call is valued and the effort they made is appreciated as an important first step in their journey to help themselves, then focusing on a reason and not on a problem is more beneficial.

Yet, the attempt to identify the reason for calling is more than just a positive psychology element. It is an important diagnostic step and also a therapeutic one. People usually seek professional help after they admit to themselves that they have a problem which they cannot handle themselves and therefore need professional assistance (Campos, 2009). Then, they usually seek a mental health professional. Contrary to that, when people call a helpline, they aren’t necessarily ready to admit they have a problem. Sometimes they will present their problem as if it was a friend's problem. Sometimes, although they want to be helped, they will enquire about the possibility to help someone else (e.g. family member or a friend).

The caller's ability to identify and define their problem is an indication of their frame of mind and readiness. Therefore, it is crucial that the helpline specialist explores the reason for calling, thus helping the caller clarifying their feelings and thoughts, and also providing the decision-makers at the helpline an indication which serves as a basis for diagnosis.

This is also a therapeutic element because many times callers are nervous and stressed when they call the helpline. They feel disoriented and disorganized. When the helpline specialist provides them with an opportunity to explore and reflect on their situation, they usually see things more clearly, which makes them feel calmer and relieved.

Exploring the reason for calling usually takes time and provides vast information. Callers describe feelings, behaviors, thoughts and symptoms. They share what they feel is 'wrong' or what they feel needs to change. They link their present situation to a past event, hypothesizing an effect. They eventually specify the distress they want to address.

The focused understanding and phrasing of the reason for calling enables the specialist and the caller to reach the final stage of the conversation – thinking about the next steps.

The final stage of the conversation is based on the rapport which was generated during the conversation, and the clarifications and understandings that were reached by the caller and specialist. Unlike the previous stages, this is a practical phase that should focus on decisions concerning future actions.

The link between what was understood and agreed upon and the final stage of making decisions is exploring the resources available to the caller. The caller is asked to identify his/her own internal strengths which can be relied upon for coping with the situation (e.g. 'what helped you cope with similar situation in the past?'). The caller is also asked to identify external resources that can be utilized to assist him/her to better cope with the situation.

Once the available resources have been identified then the caller and the specialist can brainstorm together and decide on the next steps that the caller can take. One such step can be entering into a longitudinal relationship with the helpline.

This process can be summed by Kessler et al. (1981) who said that the process of searching for help only begins in a meaningful way when the individual comes to define his/her situation as problematic. Once the problem is recognized, it is important that the individual comes to believe that professional intervention is needed. In the absence of this belief, it is unlikely that the help-seeking process will continue (Kessler et al., 1981).

After describing the first conversation, it is clear that the helpline specialist should manage a conversation which will help the caller clarify (for both parties) and identify the distress they are experiencing, the situation they are struggling with, and the actions needed in order to improve the situation.

Since the helpline specialist only has 20-30 minutes for the conversation which should include the whole process, they need to be very savvy and efficient. It is understandable that inexperienced specialist might need guidelines to help them navigate the conversation both sensitively and effectively. To this end, and as a part of the natural development of the professional practice of the helpline and LIM, a guide was created specifying targets for the first call.

The guide was created based on the experience accumulated at the helpline, and is designed to reflect the process described above.

This guide sets three objectives to be achieved during the first call. The first objective is to obtain and promote a potential for continuity of the relationship with the caller. This is an objective which is relevant only to a model like LIM, since most helplines focus on a single intervention, usually in crisis, and are not interested in maintaining a longitudinal connection.

Obtaining and promoting potential for continuity

The required goal will be achieved by referring to the emotional element: the aim is to establish a safe space and a helpful, non-threatening presence of the helper.

The helper's approach and attitude should convey a message of emotional availability and willingness to help. This is demonstrated by the tone of voice and pace of speech. It is also demonstrated by certain gestures and cues which show the caller that the helper is listening, understanding and caring.

The helper should also provide information to help the caller. This can be information regarding typical symptoms and behaviors, information about the organization or information regarding available resources. The experience at the helpline shows that providing callers with relevant (non-excessive) information usually encourages their sense of control and confidence.

Finally, the helper should get the caller's consent to maintain a connection with the helpline. The caller ought to agree to further contact which will be provided by the helpline specialist and also provide contact information (at least a phone number).

The second objective is to assess the caller's situation. This is an important step that enables the provision of a suitable assistance, during the first conversation and also in the following conversations.

Assessing the condition of the caller

Throughout the conversation, the helper should uncover the main difficulty that brought the caller to seek help.

Ingram et al. (2008) suggest that the counselor should first identify the caller's reason for calling by asking questions about what prompted them to call. James (2008) says that it is important to attempt to define the problem by gaining an understanding of the events that led to the crisis and by assessing the client's coping mechanisms.

In addition, there is a need to evaluate the caller's emotional state so that it can be assessed whether there is a critical situation (crisis, suicidal thoughts, depression or danger).

While defining the problem, the counselor must also assess the caller's current safety and their level of risk for self-harm. If it is determined that a caller is suicidal or that there is a safety concern, this then becomes a main focus of the call (Sands et al., 2013; Kevin, 2002).

The helper should identify the main problems presented by the caller (for the helper and for the helpline staff). During the conversation, there should be a discussion regarding behavioral, emotional and symptomatic indicators of the caller's condition. There should also be a discussion regarding a problem that was identified by the helper, which either the helper or the organization can react to.

Sometimes the helper may identify a certain main problem, yet the caller focuses on a different problem. It is important to pay attention to the caller's cues and discuss the problem he/she chose to bring, even if it wasn't the main problem that was identified by the helper. In such cases, it is also important that the helper indicates in their written report of the conversation, their identified main problem, as well as the caller's declared problem – so that the helpline staff can address them both.

The assessment of the caller's condition should also include an inquiry regarding the available human resources of the caller. The well-being of individuals is greatly affected by the amount of support they can receive. A support network is defined as a person's social network to which he/she routinely turns or could turn for assistance in dealing with life's challenges (Kavanaugh, Trier & Korzec, 2004).

The availability of people who can provide the individual with practical or emotional support may influence not only their welfare but also their ability to cope and recover. Dollete, Steese, Phillips and Matthews (2004) suggest that social support is both a buffer against life stressors as well as an agent promoting health and wellness.

To that end the helper should ask more than just: "Do you have someone to talk to?" The helper should map the support network of the caller (parents, relatives, friends, neighbors, roommates…) while gathering as much as specific information as possible.

This process of mapping the caller's support system is essential as part of the assessment, but it is also beneficial for the callers, who are unaware at times to their own resources, and this process may help them recognize their assets. Many times the helper asks the caller if he/she has someone they can talk to, to which the caller negates. Yet when the helper continues and asks about people who helped the caller in the past or someone they shared with previously, then the caller may realize that they have resources available.

A process of network exploration can also lead to the identification of people who are generally more peripheral but nevertheless may be potentially helpful.

Additionally, Tedeschi and Calhoun's (2004) revised model of posttraumatic growth includes social support as a predictor of positive change in the aftermath of traumatic events (Prati & Pietrantoni, 2009). Accordingly, when people grieve, they recover and find wholeness as part of larger wholes as they reconnect with family, friends, and community (Frantz et al., 2001; Attig, 2001).

To conclude, social networks influence the physical and mental health status of individuals (Berkman & Glass, 2000); therefore, an assessment of a caller (individual) must include a reference to their social network.

The third objective is to set a foundation for an action plan with the caller. Usually, helplines' interventions don't include additional involvement to the initial contact. Helplines mostly provide one-time crisis intervention, which typically ends in referring the callers back to their doctors, mental health professionals etc. Usually, the caller might be asked to reach out to friends and family, sometimes they will be asked to reach out to a therapist (Dinakar et al., 2014), and in some cases a referral is made to other services (Roberts & Yeager, 2005; Sands et al., 2013).

Setting the foundations for an action plan

The LIM specifically directs the helpline specialists to create an action plan with the caller, during the first call.

The helper should discuss and offer an action plan, or lead the caller to make one of their own. The action plan can be a partial one, yet it ought to include practical steps for the near future. It should direct the caller to achieve specific and measurable goals.

Moreover, the caller should explicitly consent to the action plan, or at least commit to think about it until the next conversation.

The planning of an action plan, during the conversation, conveys a message of competency to the caller. During the conversation, the caller describes his/her difficulties, to which the specialist expresses empathy and understanding. Then, the specialist enquires to the way the caller tried to cope with these difficulties. The final step is to summarize the efforts of the caller up to that point and think together about potential steps which can be taken to improve the situation. Crisis interventions should include an action plan, as Dinakar et al. (2014) and Kitchingman et al. (2015) suggest, since the formulation of simple steps is aimed at helping the callers tide over their crisis.

This outcome is of great importance according to the LIM, due to the aspiration to end the conversation with the caller at a point connected to strengths, looking forward to the future, and in a place of hope. The existence of an action plan is a validation to the caller that the situation is not hopeless, that he/she has tangible practical options, which have the potential to improve the situation.

It is also a crucial part of the conversation consistent with the LIM view which attempts to establish a road map to encourage the caller's journey to recovery. This action plan can determine that the caller is ready and willing to start speaking with the helpline specialist on a weekly basis. It can determine that the caller is ready and willing to start meeting a mental health professional. It can also determine that the caller is finally ready to share his experience with his family members. No matter which action is planned – as long as there is a plan, as long as the caller is committed to act and start his/her journey, then this is the first small achievement encouraged by the helpline.

Neither the caller nor the specialist should be deceived by this action plan. The creation of the action plan is small progress in a very long process. There will be ups and downs, highs and lows, progress and setbacks. Yet, it is important to be aware of and to emphasize the fact that the caller, by making the first call to the helpline, actually took the initiative, made the first step towards helping himself/herself. The action plan is an acknowledgment of this important first step, and also a declaration of commitment to proceed.

This guide which sets these three objectives to be achieved during the first call proved to be very helpful for the specialists. Setting clear goals is always helpful for practitioners, as it helps focusing the attention and efforts, and also directs the intervention itself. Similarly, the ability to develop the LIM, and to improve the practice by better defining the roles of the specialist was beneficial for callers and staff.

This can also demonstrate the importance of continued change, development and improvement of new endeavors, which can be well-designed during the planning phase, yet there is an opportunity to utilize real-life experience to advance and improve the service (Leonard et al., 2013; Laszlo et al., 2009).

Another major change, which affected both the LIM and the helpline operation, involved the professional guidance and supervision for the helpline specialists regarding the cases under their care.

Supervision and quality assurance

'Quality is not an act, it is a habit'.

Aristotle

(Barnes, 2014)

The word supervision derives from the Latin *super* ("over") and *videre* ("to watch, to see"). Hence, a supervisor is defined as an overseer- one who watches over the work of another with responsibility for its quality (Kadushin & Harkness, 2014).

In the therapeutic context, supervision is defined as a working alliance between the supervisor and counsellor in which counsellors/therapists can offer an account or recording of their work; reflect on it; receive feedback and where appropriate, guidance. The object of this alliance is to enable the counsellor/therapist to gain in ethical competence, confidence, compassion and creativity in order to give their best possible service to the client (Inskipp & Proctor, 2001; Wheeler & Richards, 2007).

Supervision has several purposes, such as the facilitating the professional and personal development of supervisees, the promotion of counselor competencies, the promotion of accountable counseling-services and programs (Bradley & Ladany, 2001).

Carroll (2001) emphasizes that the primary goal of supervision is to ensure the welfare of clients.

Accordingly, in the early days of the operation of NATAL's helpline, there was a deliberate effort to ensure providing the best service possible for callers. A protocol of case management was implemented.

Phase 1

Every call received at the helpline, after being documented by the specialist who received the call, is reviewed by the helpline manager.

In the first few years, the helpline manager read the documentation and provided each specialist with a written supervision.

The written supervision included an observation regarding the caller's situation, his/her challenges and strengths/resources. It also offered an analysis of the experiences which led to this

situation/problem. Finally, the written supervision directed the specialist to themes which require supplementary exploration, and suggested a roadmap for the intervention.

The case was then assigned, by the helpline manager, to a certain specialist, who was provided with the written supervision and given the responsibility to work with the caller and lead the longitudinal intervention.

A special effort was made by the helpline manager to match between each caller and the specialist working the case. Based on the observation and the analysis of the case, the helpline manager attempted to tailor the intervention to the caller's situation and needs – an important part of such tailoring is assigning a specialist who is able to best provide these needs which were identified. For example, a caller suffering from chronic PTSD, who is expected to make a slow progress (if any), will be assigned to a tenacious and optimistic specialist, while an emotionally flooded caller will be assigned to a calm and containing specialist.

The specialist, following the guidance of the helpline manager, started the intervention, during which he/she documented each conversation with the caller. Every few weeks, the case was sent back to the helpline manager for another review and additional guidance. Usually, the initial written supervision instructed the specialist when and under which conditions he/she should seek additional guidance. Yet, the specialists were also told that they can ask for supervision whenever they feel the need to.

Fortunately, the positive atmosphere at the helpline and the solid alliance that was established between the specialists and the helpline manager facilitated the supervision to a point where specialists were asking for supervision after each conversation.

This supervision protocol was suitable for a small helpline, which does not receive many calls, and does not engage many specialists. Alongside the development of the helpline, and with the growing needs, it was necessary to modify the operation and the protocol.

Phase 2

With the increase in the number of calls/callers and specialists, it was evident that there is a need for additional manpower to manage the cases. Therefore, a revised protocol was employed.

The helpline manager continued to read and review each incoming call, and also continued to choose and assign the specialist for each case. For the majority of the cases, the helpline manager continued to provide the written supervision. Yet, the ongoing supervision had to be delivered by additional personnel. For that reason, several experienced specialists, who provided the service at

the helpline for several years were selected and especially trained to serve as supervisors for inexperienced specialists.

These supervisors were assigned one to three specialists to whom they provided guidance. They met with the specialists every week, discussed the written instructions, answered questions and provided support. They utilized their own experience at the helpline and the supervision they were given (past and present) to assist the specialists.

During busy times, the helpline manager gave verbal instructions to the supervisors, who then prepared accordingly written supervisions for the specialists.

Another guidance and professional development structure was created – peer supervision groups. Peer group is a group of people who share certain social characteristics, such as age, occupation, or education, and interact on a level of equality (Barker, 2003; Reber, 1995).

Peer supervision differs from more traditional forms of supervision in that it doesn't require the presence of a more qualified, identified expert in the process - a supervisor (Rushton, 2015; Schreiber & Frank, 1983).

Peer supervision group is an effective form of leaderless peer group counselling. Peer supervision group offers a good opportunity for peers to work together at regular intervals in order to confer with one another and discuss systematically the key topics or problems of their professional daily work life and to develop suitable solutions (Kadushin & Harkness, 2014; Brashears, 1995). Peer supervision is a reciprocal arrangement where developmental feedback is emphasized and self-directed learning and evaluation is encouraged (Cohen, 1999; Benshoff, 1994).

A growing body of evidence exists to support the potential contributions of peer supervision for both trainee and experienced counsellors (Golia & McGovern, 2013; Noble & Irwin, 2009; Benshoff, 1994; Hansen, Robins & Grimes 1982). It provides better exchange of knowledge between colleagues, it could serve as a valuable source for coping with difficult professional issues and it offers the participants sympathy and support in difficult situations. For the organization, it offers an opportunity for personnel development at low costs, and an improvement of quality of work, quality assurance and better work performance (Rushton, 2015).

Although, peer supervision potentially has many advantages, there are also a number of potential risks, such as overabundance of advice giving and less than helpful responses, boundaries issues, personalities or group dynamics which may lead to individuals dominating while others become passive – all of which can have an impact on the quality of the supervision (Manthorpe, Moriarty, Hussein, Stevens, & Sharpe, 2013; Beddoe, 2012).

This arrangement helped ease the burden of the helpline manager and supported the daily operation of the helpline. It enabled the specialists to receive continual, systematic and consistent

supervision which sustained their work at the helpline. In addition, this arrangement has proven to be beneficial also for the veteran specialists, who found additional interest, satisfaction and meaning in their new role. Yet, it also had some flaws which affected the atmosphere at the helpline and the daily practice of the specialists. Theses flaws were not apparent and obvious at first, and took time to recognize.

The continued development of the helpline, the complexity of the cases and the experience accumulated led to another developmental change, both in operation and supervision.

Phase 3

After ten years of operation, the field experience and the feedback received from the helpline's clients strongly indicated that the LIM is helpful in promoting the recovery of trauma and loss survivors, and that clients find the relationship with the specialist and the helpline not just satisfactory, but also useful, valuable and empowering.

It was time for reflection on the practice of the LIM and exploration of the therapeutic process and its outcomes.

The helpline management and the executive directors of NATAL came to the conclusion that quality assurance should include methodical evaluation and research. The process of planning and designing such evaluation and research prompted feedback and insights from clients, specialists, and supervisors. It led to the realization that there are undesirable inconsistencies in the quality of the interventions and supervisions. Therefore, the helpline manager instigated a revision and modification of the practice at the helpline, which predominantly effected the treatment, the assessment and the supervision.

The ambition to provide clients with the best service possible is the engine of change and improvement of the LIM. The more professional the service the more beneficial it is for clients. Yet, the NATAL helpline and the LIM are relying on non-professional specialists to provide the service. Therefore, it is clear that professional practice can be achieved by professional supervision.

Lawton and Feltham (2000) claim that there is a wide consensus as to the need for a certain amount of supervision input for trainees in the various clinical professions. Yet, the NATAL helpline is operated by non-professionals, therefore it arises the question whether supervision is less or more needed by/for non-professionals.

The term paraprofessional denotes "persons with some of the skills and natural helping talents of the professional. They usually work directly with clients under the professional's supervision for

training and accountability (Brammer & Macdonald, 2003; Corey & Corey, 2015). Under the labels of "paraprofessionals", "nonprofessionals", and "mental health volunteers", these individuals compose a significant portion of those who deliver mental-health-related service (Walfish & Gesten, 2008).

Many scholars (Azar, 2000; Newton, 2000; Walfish & Gesten, 2008; Sotelo, 2015) suggest that clinical supervision should be in place to support the professional development of paraprofessional counselors and to address the concerns about their ability to practice ethically and competently.

The helpline management decided to provide the specialists with professional supervision, with the aim of bettering their practice, which will provide high quality interventions for clients. To this end, a group of qualified supervisors (clinical psychologists and clinical social workers) were chosen and trained by the helpline management. These mental-health professionals provide the specialists with formal clinical supervision, twice a month.

This decision generated a major change affecting the LIM and the helpline operation. It put to order the process of supervision: the professional supervisors have no role or responsibility at the helpline other than supervising. The envy that disturbed the atmosphere at the helpline, regarding positioning some veteran specialists as supervisors, while others weren't given the same opportunity, has calmed. Also, the new supervisors had pre-set appointments with the specialists for supervision sessions, thus stabilizing and regulating the supervision.

Perhaps the most significant effect of the professional supervision regarding the LIM is that it facilitated better monitoring and shaping the practice of the specialists.

To assist and direct the specialists' work an emphasis was placed on the need to set treatment goals and to work with clients towards achieving those goals.

Goals affect performance by focusing attention, directing effort, increasing motivation and enabling the development of strategies to achieve one's objectives (Locke, 1968; Hurn, Kneebone & Cropley, 2006).

The importance of goals in psychological treatments has been emphasized in the empirical literature. A meta-analysis reported substantial empirical support for the effect of goal consensus and goal collaboration to psychotherapy treatment outcome (Tryon & Winograd, 2011; Jansson, Tham & Ramnerö, 2015).

Setting goals provides a focus for therapeutic work, criteria for evaluation of progress and a shared narrative, that may serve to clarify the respective roles of the client and the therapist. Furthermore, the very process of formulating goals may exert a therapeutic effect in itself (Holtforth & Castonguay,

2005; Jansson et al., 2015). Von Roenn and von Gunten (2003) argue that setting goals in therapy is a way to maintain hope. In practice, goal setting is an implicit or explicit part of almost all health-related intervention (Strecher et al., 1995).

To set goals, one needs to name them and understand how he/she is going to get there and how he/she will know whether they have been achieved (Von Roenn & von Gunten, 2003). Once the therapist and client decide to work together, they set goals for treatment and negotiate their relationship. In some cases, therapists and clients negotiate openly about what will take place in the process, but in other cases the negotiation is more covert and the client has to intuit the therapist's rules for interpersonal engagement, what to talk about, and how to proceed (Haley, 1986; Hill, 2005). Because patients' expectations can sometimes be unrealistic, treatment goals should be discussed and then reassessed at follow-up visits (Marschall-Kehrel & Spinks, 2011).

In cases of trauma and loss, goal-setting has great importance. It has been found by Holcomb (2012) that most bereaved adults can benefit from some form of goal setting and activity scheduling, especially those who have been widowed or who are experiencing complicated grief. In fact, goal-setting should be a concrete and reassuring method of stress reduction during the chaotic aftermath of sudden traumatic death. It provides direction with tasks on which to focus and accomplish, thereby providing an underlying message of future orientation as well as some sense of control over an otherwise seemingly out-of-control life (Clements, DeRanieri, Vigil, & Benasutti, 2004). After trauma or the loss of a loved one, intense feelings of distress can cause basic self-care activities (such as daily hygiene, eating, and getting enough sleep) to become challenging. Therapists can assist the survivor in reducing the overwhelming snowball of self-care challenges into manageable parts by providing guidance in setting appropriate self-care goals, monitoring process, and providing support for maintenance of these goals (Holcomb, 2012).

In sum, there are evident advantages and benefits to setting therapeutic goals – for therapists and patients alike. Therefore, as part of the development of the LIM and the helpline practice, it was decided that the supervisors will guide the specialists through the process of goal-setting with their clients, and then will monitor the achievement of these goals.

This new practice wasn't designed to be bureaucratic or technical. Its purpose was to shed light over the thought-process and the decision-making of the specialists. This generates more transparency of the therapeutic process – towards the clients, the supervisors and the helpline management. Such process promotes awareness and self-reflection, which may lead to a more focused and precise intervention.

The new procedure included several steps of goal-setting and then several steps of assessment and monitoring. Goal-setting was first discussed between the specialist and the client, in an open and

candid manner to allow the client state his/her wishes and needs – from which the therapeutic goals were driven. Then, the specialist and the supervisor discuss the goals aspired by the client, and plan some working strategies which may promote the achievement of these goals. Next is the work done by the client, with the guidance, assistance and support of the specialist.

The monitoring is first done by the supervisor and the specialist, who work together to assure the therapeutic process is heading towards the desired objectives. However, in order to assure quality standards, it was decided to ensure the achievement of the therapeutic goals by the implementation of an assessment process.

This process included an intervention assessment through a progress report, carried-out every six months. The progress report involves the collaboration of the client with the specialist, and the specialist with the supervisor. Every six months, the specialist initiates a reflection and summation process, where he/she and the caller check the goals they previously set and assess the progress made in achieving these goals. Then they can notice the goals which haven't been achieved and discuss the inhibitors that delay the process and look for strategies to overcome those inhibitors.

The therapeutic process, like any other process is a natural phenomenon marked by gradual changes that lead toward a particular result (Hornby & Wehmeier, 1995; Rice & Greenberg, 1984). These gradual changes, as the definition implies, are slow and therefore, sometimes difficult to be noticed or recognized. The assessment promotes the recognition of change and progress, which can provide the client encouragement and hope.

After the assessment was done by the client and the specialist, a similar process is done by the specialist with the supervisor. They fill a progress report that is monitored by the helpline management and also is filed with the case notes of the client. The progress report specify the goals that were previously set, the goals which were achieved during this period of the longitudinal intervention, and the goals which are currently being set to be achieved in the next six months.

This process not only focus and helps efforts to be more efficient, it also helps in seeing the process as a whole, from start to end, noticing the different stages/steps, the progress and setbacks, and the different strategies and therapeutic approaches utilized during the process.

As it turned out, this change of professional supervision, goal-setting and progress assessment also led to another major development, which also instigated this research – a methodical procedure to evaluate the practice and the outcomes of the LIM.

PART V

Research

Chapter 8

Evaluation of Helplines

This chapter focuses on the evaluation of helplines. First, it presents a literature review of researches evaluating face-to-face counseling, and then reviews researches evaluating telephone counseling. Second, it addresses the difficulties in the study of helplines.

The expansion of telephone counseling services has led to increased interest in appropriate evaluation techniques (Bryant & Harvey, 2000), especially since these services have the potential to meet gaps in services brought about by professional health workforce shortages, and, indeed, have been used in this capacity in recent years (Burgess, Christensen, Leach, Farrer, & Griffiths, 2008). In fact, the evaluation process is the most important issue crisis intervention services are facing (Lester, 1995); because it is sometimes claimed that such services have little effectiveness beyond referral and support (Hornblow, 1986). Additionally, due to the fact that resources are often scarce, and there is a need to compete for limited funds for operation (Mishara & Daigle, 2001; Lester & Rogers, 2012), these services will be increasingly called upon to assess their impact on the community and confirm that they are meeting their stated goals.

Evaluation of face-to-face counseling versus telephone counseling

'An ounce of action is worth a ton of theory'.

Ralph Waldo Emerson

(Emerson, Bosco, & Myerson, 2015)

Psychotherapy is traditionally based on face-to-face interactions or other settings that involve verbal and non-verbal language without any technological mediation. However, emerging technologies are modifying these traditional settings (Castelnuovo, Gaggioli, Mantovani, & Riva, 2003). One of these technologies is the telephone helpline, which is increasingly becoming the community's principal source and provider of information, 'help', 'support' and/or 'advice'. Whereas previously (e.g. less than a generation ago) someone might routinely seek consultation with an 'expert, solely in a face-

to-face encounter, nowadays one is increasingly being encouraged to call the relevant helpline when a ‘problem’ arises, when ‘expertise’ is required, or simply when a ‘question’ needs answering (Firth et al., 2005). In fact, many people who have been unable to seek help through conventional modalities have been able to receive psychological support and counseling from a telephone counseling service (Williams & Doubs, 2012; Lester & Rogers, 2012).

Over the years, telephone counseling has received attention in the literature as an attractive alternative to traditional face-to-face counseling (Reese et al., 2002). However, it was not until the 1970's that researchers began to try to understand the nature of the telephone help services and to evaluate their effectiveness (Lester & Rogers, 2012).

According to Apsler and Hoople (1976), during this period of time the development of evaluation techniques has not kept pace with the emergence of telephone counseling services. Despite the rapid and extensive growth of hotlines in the 70's, few efforts have been made to adapt existing techniques or to create new ones in order to evaluate the impact of hotlines on the populations they service or to study and improve the processes through which they operate.

In fact, this trend continued in the following years, while many studies used the same methodologies that were being used in evaluations of face-to-face psychotherapy (Goodman & Dooly, 1976; Lambert, Christensen & DeJulio, 1983; Greenberg & Pinsof, 1986; Hill & Corbett, 1993; Bergin & Garfield, 2003; Lester & Rogers, 2012). The theoretical model that is the basis for these evaluations was generally the Rogerian approach that specifies several well-defined techniques that are supposed to be conductive to positive therapeutic outcome (Rogers, 1951; Truax & Carkhuff, 1967).

These techniques (but not necessarily the entire Rogerian therapeutic method) are also relevant to telephone crisis interventions since they are often taught to volunteers in different centers (Lester, 2001).

Difficulties in the study of helplines

'Experience without theory is blind, but theory without experience is mere intellectual play'.

Immanuel Kant

(Kant, 1996)

Evaluating services, as clear measurable outcomes are difficult to establish in telepsychology environment. Numerous approaches have been used to evaluate telephone counselling, all having the limitation of a methodological or practical nature. These limitations arise from the fact that generally it is not possible in this research context to use before and after measures, control groups and standardized psychological tests or clinician ratings (Campos, 2009).

In practice, effectiveness studies of treatment are usually based on a survey of large numbers of people who have gone through such treatments (Seligman, 1995). Although there are many studies evaluating telephone crisis services, they take different and varied approaches of the evaluation process.

Kalafat, Gould, Munfakh, & Kleinman (2007) present the major assessment approaches that have been utilized by researchers, which include (a) counselors' estimates of their own helpfulness; (b) in vivo evaluations of various aspects of counselor behavior; (c) clients' reports of therapeutic impact; (d) changes in suicide rates as a function of the presence of telephone crisis services; (e) success of counselors at referring clients to other agencies. However, there are indications that therapists' evaluations of the outcomes of their clients are problematic in that they tend to be nonspecific, unstandardized, and are subject to biases not found among more objective indices (Stein & Lambert, 1984; Campos, 2009).

In general, there are several methods and strategies in place to evaluate helplines and hotlines for the purpose of demonstrating their effectiveness to their clients, while some of them focus on the callers and others on the helpers. For example, a known strategy which relates to the callers is the examination of changes in their suicide state from the beginning to the end of their calls (Gould, Kalafat, Harris Munfakh, & Kleinman, 2007). Likewise, requesting callers to evaluate their satisfaction of the counseling they receive is another way to evaluate helplines, although this strategy has some drawbacks (Bryant & Harvey, 2000).

Unlike these, some methods are aimed to evaluate the helpers themselves by focusing on their behaviors. This can be done, for example, by using the Helper's Response List, described by Mishara and Daigle (1997), which consist of behaviors that helpline workers can do, both good and bad, while on the helpline. The purpose of this tool, in the context of Mishara and Daigle's study, was to determine which of the behaviors was associated with better outcomes. In a similar manner, the Fowler Technical Effectiveness Scale (Fowler & McGee, 1973) evaluates worker behavior with a series of simple yes or no questions. Another notable tool is the Truax and Carkhuff scale (1967), which rates the empathy of the responses that the worker gives to a statement or statements by the caller. Every time the worker speaks, their interaction is rated on the scale (Lester & Rogers, 2012).

Some approaches have been criticized because they rely on inaccurate assumptions about the purpose of the service, involve biases in measurement technique, or neglect the influence of other factors on the measurement variable. For example, previous studies of telephone counseling services requested callers to subsequently evaluate their satisfaction of the counseling they receive (Bryant & Harvey, 2000). Mishara et al. (2007b) noted that they have not come across a study in which clients were asked to rate their satisfaction with helpline services that did not show highly positive results. According to them, one of the reasons satisfaction studies may always get positive results is the fact that those who were satisfied are more likely to respond to follow-up than those who were not. Because the results are always positive no matter how questions are asked, whom you ask, or what center is conducting the study, satisfaction studies appear to have little value as indicators of success of helplines.

Another example concerns the neglect of the influence of other factors on the measurement: the fact is that callers are affected by a multitude of life circumstances and may engage in other help-seeking activities. This issue is very important because it is a great challenge to differentiate effects that are related to telephone intervention from the effects of other life activities (Mishara et al., 2007b). Similarly, the overall dynamic nature of the counselling process produces too many variables that may identify specific elements deemed effective. According to Bobevski and McLennan (1998) and Campos (2009) counselling research fails to identify elements of the counselling process with measurable outcomes.

It is reasonable to assume that in order to evaluate the effectiveness of helplines a researcher should investigate the process of intervention. Such studies have been conducted referring to two perspectives: technical aspects (accomplishing certain tasks during the call) and clinical aspects (qualities of interventions that are considered to be helpful according to a theoretical perspective).

Technical aspect studies are based on the assumption that doing certain things during a call will have beneficial effects. They focus on whether or not essential tasks in telephone interventions are completed, such as securing the communication with the caller, assessing the caller's condition and

developing a plan of action (e.g., Fowler & McGee, 1973; Mishara & Daigle, 2001). In contrast, studies of clinical aspects of telephone interventions assess the presence of "facilitative therapeutic relationships" as described by Rogers (Rogers, 1951; Truax & Carkhuff, 1967), generally measuring empathy, warmth, and genuineness (Mishara et al., 2007a).

A recent paradigm, which has been conducted according to these perspectives, employed simulated telephone calls to telephone counseling services as a means of evaluating the quality of counseling provided by the telephone counselors. General counseling skills included: Rapport (the degree to which the counselors established a relationship with the caller); Acceptance (the degree to which the counselors displayed acceptance of the caller's presentation); Empathy (the degree to which the counselors responded empathically to the caller); Understanding of veteran issues (the degree to which the counselors displayed an understanding of veterans' terminology and experiences in Vietnam); Understanding psychopathology (the extent to which the counselors displayed understanding of the common psychopathological symptoms); Assessment of risk (the degree to which the counselors appropriately indexed the level of risk of the caller to harm himself or others); Information provision (the amount of appropriate information that the counselors was able to provide to the caller in response to the stated need); Advice (the degree to which the counselors provided appropriate options to assist management of the presenting problem) (Bryant & Harvey, 2000).

Young (1989) found that callers valued being given clear and accurate information, being helped to organize thoughts, discussing alternative solutions, and being provided with a new perspective, along with the opportunity to talk, and accept support and reassurance. Also, Cooper et al. (2011) found that the need for a genuine and sincere contact was repeatedly stressed by service users and staff members as important in any intervention. However, as has been found in psychotherapy research, the relationship between the helper and the caller is necessary, but not a sufficient aspect of effective helping. Clearly, it is also important for callers to focus on identifying and resolving their presented problem (Kalafat, 2012).

This connection, between caller and helper, has to be built up and maintained turn by turn, as the conversation unfolds. An important principal for researchers is to look at very fine details of how turns are designed, at how next turns are related to prior turns, at how spaces in the talk are filled or not filled. By doing that it is possible to find the conversational machinery (and the conversational art) through which the listening and caring is done (Danby et al., 2005). Understanding the relevant themes/objectives to which help providers orient within that context has the potential for creating a richer, better informed analysis of telephone-mediated help (Pudlinski, 2005).

Another option for researchers is to approach the evaluation from the position that certain aspects of a telephone counselor's behavior can be assessed on measures that presumably related to client improvement (Stein & Lambert, 1984). In fact, improvement in general functioning, as well

as symptom relief, is almost always a goal of actual treatment (Seligman, 1995). These types of studies have assessed the presence and timing of the components of the helping model and examined their relationships to caller outcome through follow-up calls to callers. The presence and timing of these components were related to positive caller feedback and outcomes such as relief of distress, confidence, and emotional awareness (Kalafat et al., 2007).

Over the years, various studies have demonstrated that telephone counseling was effective for a variety of populations with diverse needs: it is shown to be an effective tool in reducing anxiety among cancer patients (Mermelstein & Holland, 1991; Badger et al., 2007; Cox & Wilson, 2003); low-income and minority patients (Miller et al., 1997; Taylor, Baranowski, & Young, 1998; Dwight-Johnson, Ell & Lee, 2005); the elderly (Guy, 1995; Lee et al., 2009; Stephens & Allen, 2013); gay and bisexual men (Bertera & Bertera, 1981; Roffman et al., 1997; Carballo-Diéguez et al., 2005); concerning HIV testing (Roffman et al., 1998; Gardner et al., 2011; Muessig et al., 2013); hypertensive patients (Bertera & Bertera, 1981; Glanz, Kirscht, & Rosenstock, 1981; Bosworth et al., 2008); patients of young children with minor concerns (Katz, Pozen, & Mushlin, 1978; Thome & Alder, 1999; Coker et al., 2013); physically disabled (Evans, Fox, Pritzl, & Halar, 1984; Weinberger et al., 1989; Sullivan et al., 2005; Devos-Comby, Cronan & Roesch, 2006; Khan, Pallant, Brand, & Kilpatrick, 2008; Rimmer et al., 2009; Knittle et al., 2015); visually impaired (Jaureguy & Evans, 1983; Beverley, Bath & Booth, 2004; Garnefski et al., 2010); smoking cessation groups (Zhu et al., 1996; Whittaker et al., 2012; Free et al., 2009; Ybarra et al., 2016); inner-city children (Szendre & Jose, 1996; Wu & Pai, 2014; Aldiss et al., 2015); and black urban youth (Tolmach, 1985; Newman, Szkodny, Llera, & Przeworski, 2011). Also, it has been demonstrated to be effective in treating people diagnosed with minor depression (Lynch, Tamburrino, & Nagel, 1997; Tutty et al., 2010; Kauer et al., 2012; Proudfoot et al., 2013), and in treating those clients who were unable to attend counseling in person due to health problems impacting physical mobility (Evans, Smith, Werkhoven, Fox, & Pritzl, 1986; Stein, Rothman & Nakanishi, 1993; Masi & Freedman, 2001).

Studies, which some of them used these methods and others, have shown that there is no support for the idea that face-to-face is superior to interventions delivered over the telephone (Coman et al., 2001; Tse et al., 2012). Opdenacker and Boen (2008), for example, found that both face-to-face support and telephone support proved to be effective in increasing the physical activity level and mental health of university employees.

Also, Tse et al. (2012), who compared the effectiveness of the two different intervention modalities in controlling gambling behaviors and reducing the harm caused by problem gambling, found that the clinical outcomes for the telephone intervention were similar to those for the face-to-face counseling. A similar trend was reflected in the work of Antonioni (1973), who found similar levels of counselor empathy and client satisfaction for telephone and face-to-face therapy in the initial

sessions, and in another study which found that telephone assessment of Axis I and Axis II disorders (from the DSM 3rd Edition Revised) can be as effective as face-to-face assessment (Masi & Freedman, 2001).

Moreover, Reese, Conoley, & Brossart (2006) who studied the effectiveness level of telephone counseling found that it was even higher than that of face-to-face counseling. In their research they surveyed clients who had received counseling services from a private telephone counseling agency as part of an employee assistance program. Of those responding, 96 percent said that they would use the service again, and more than half (58%) preferred the telephone contact over face-to-face meetings.

In 2008, Morgan, Patrick and Magaletta compared inmates' perceptions of the working alliance, post-session mood, and satisfaction with psychiatric and psychological mental health services delivered through 2 different modalities: tele-mental health and face-to-face. Their goal was to explore the impact of service delivery modality on the therapeutic relationship – that is to find out if the traditional face-to-face service delivery modality superior to nontraditional and innovative modalities aimed at increasing access to care.

This study represented an empirical investigation from the field and clearly indicated that the modality used for providing mental health services (i.e., tele-mental health vs. face-to-face) did not negatively impact key elements of the treatment experience. Specifically, the therapeutic relationship with the mental health professional, post-session mood, or overall satisfaction with services received were not different between tele-mental health and face-to face treatment modalities.

When it comes to delivering specific treatments, telephone counseling is also as effective as face-to-face therapy, and sometimes even more. In fact, Mohr et al. (2012) found that Telephone CBT improves adherence compared with face-to-face delivery among primary care patients with depression.

To conclude, recent years' research indicates that there is no difference in the effectiveness and quality of telepsychology services in comparison to face-to-face services. It could be claimed that such comparison may not be appropriate given that telepsychology services create a different environment for counselling than face-to-face (Campos, 2009).

Yet, presently, the research is unable to provide any conclusive statements on the effectiveness and quality of telepsychology services as such due to the lack of reliable and valid evaluation tools developed for telepsychology. Therefore, comparative research in evaluating the effectiveness and quality of these services is limited.

Chapter 9

Methodology

Research methods

'Men love to wonder, and that is the seed of science'.

Ralph Waldo Emerson

(Emerson et al., 2015)

This research poses two challenges: the first one is similar to any study of helplines, as described above – currently; there are no consensual tools for evaluation developed for telepsychology which can be used here. Secondly, NATAL's helpline and the LIM it is based upon are unique in nature and philosophy from most helplines and therefore cannot be evaluated based on standard tools. The therapeutic approach of the LIM is uncommon for helplines, specifically the ones relying on non-professional personnel, which present an additional challenge for evaluation.

These challenges led to a research design which combines varied and unusual research methods. This decision can be supported by Morse (1999) who concludes that there is a need for other and different methods—if we are to understand the complexity of living.

Reinforcement can be found in Danby et al. (2005) who suggest that different studies of helplines present irregularities of research questions, methods and outcomes - all these regularities reflect significant elements of the philosophy of the helpline. Therefore, they believe that helpline research should attempt to locate in the data itself a clear sense of the helpline philosophy-in-action.

Morse (1999) suggests that different research methods use different research perspectives and different types of data according to the question asked.

Quantitative research is the systematic empirical investigation of observable phenomena via statistical, mathematical or computational techniques (Creswell, 2013). Some scholars emphasized the use of the scientific method through observation to empirically test hypotheses explaining and predicting what, where, why, how, and when phenomena occurred (Rogers, Howard & Vessey, 1993; Bernard & Bernard, 2012).

Quantitative psychological research is the study of methods and techniques for the measurement of human attributes, the statistical and mathematical modeling of psychological processes, the design of research studies, and the analysis of psychological data (Wood & Brown, 1994; Michell, 1997). Quantitative psychology includes research and development in a number of broad areas: measurement, research design and statistical analysis, as well as mathematical and statistical modeling of psychological processes (Aiken, West & Millsap, 2008).

Qualitative approaches express a constructivist philosophy which holds that human knowledge is socially and personally constructed, with no single view laying claim to universal validity or absolute truth. The goal is less to generate incontestable “facts” than to discover and explore the unique and common perspectives of the individuals being studied (Neimeyer & Hogan, 2001).

Such methods are especially valuable in generating theory where little good theory exists, in revealing how people make meaning of events, and in moving toward a deep understanding of a particular phenomenon (Neimeyer & Hogan, 2001).

However, many studies, such as those compering distant mediums to face-to face communication, make conclusions based on quantitative measures with little reference to subjective qualitative measures (Campos, 2009). These studies may ignore some of the unique features of qualitative methods, which offer alternatives in analytic approaches; cater to different disciplinary perspectives, assumptions, and agendas; provide means to explore various levels of analysis, from micro-analytic to complex behaviors; and permit the development of the necessary level of conceptualization of results (Morse, 1999).

Although a distinction is commonly drawn between qualitative and quantitative aspects of scientific investigation, it has been argued that the two go hand in hand (Mertens, 2014).

In the past, qualitative research methodology has been employed to explore the explanatory understanding of theoretical and empirical findings (Cooper et al., 2011). Qualitative research produces information only on the particular cases studied, and any more general conclusions are only hypotheses. Quantitative methods can be used to verify which of such hypotheses are true (Hanson, Creswell, Clark, Petska, & Creswell, 2005).

Hence, it seems necessary that researchers will pay attention to "*mixed methods research*" – a "class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, into a single study" (Johnson & Onwuegbuzie, 2004; Yin, 2009).

The mixed methods design is a research which forces the methods to share the same research questions, to collect complementary data, and to conduct counterpart analyses. Mixed methods research can permit investigators to address more complicated research questions and collect a richer and stronger array of evidence than can be accomplished by any single method alone. By definition, studies using mixed methods research are more difficult to execute than studies limited to single methods. However, mixed methods research can enable to address broader or more complicated research questions (Yin, 2009).

Also, Cooper et al. (2011) suggest that qualitative data might help researchers gain an understanding of the underlying psychological mechanisms and aspects of the design of the interventions that might be of benefit or detriment to patients which a quantitative study could not be expected to elucidate.

This research aims to explore a unique model, attempts to gain a deep understanding of unfamiliar uncommon territory and hopes to provide good theory which may support current and future users. Such research may benefit greatly from a mixed methods design to achieve its goals.

Another characteristic of this research is that it is a naturalistic study, in contrast to well-controlled, experimental study. A naturalistic research is a type of study in which the researcher very carefully observes and records some behavior or phenomenon, sometimes over a prolonged period, in its natural setting while interfering as little as possible with the subjects or phenomena (Shenton, 2004; Petty, Thomson & Stew, 2012).

The researcher being an integral part of the organization and the model studied, it is natural that their presence will be perceived as part of the normal environment within which the subject of the study functions, thus enabling a naturalistic research.

With the aim to address the challenges of a naturalistic study, this research applies *triangulation*. Patton (2001) suggests that triangulation can be used in both quantitative (validation) and qualitative (inquiry) studies.

Triangulation indicates that two (or more) research methods are used in a study in order to check the results of one and the same subject (O'Donoghue & Punch, 2003). Triangulation is a powerful technique that facilitates validation of data through cross verification from two or more sources (Bogdan & Biklen, 2006).

By combining multiple observers, theories, methods, and empirical materials, researchers can hope to increase the credibility and validity of the results (Angen, 2000). Therefore, currently, triangulation becomes an alternative to traditional criteria like reliability and validity in qualitative analyses.

Furthermore, triangulation can provide another advantage – since a single method can never adequately shed light on a phenomenon, using multiple methods can help facilitate deeper understanding (Flick, 2004).

Similarly, Cohen and Manion (2000) define triangulation as an "attempt to map out, or explain more fully, the richness and complexity of human behavior by studying it from more than one standpoint

To conclude, there is an agreement among scholars that triangulation gives a more detailed and balanced picture of the situation (Altrichter, Feldman, Posch, & Somekh, 2013). This research, therefore, uses triangulation to achieve both targets - to produce understanding and to find credibility.

Quantitative methodology

'You can get along very well in this world by simply coming up with a quantity of reasonably valid statements'.

B. F. Skinner

(Skinner & Ferster, 2011)

During the 17 years of its existence, NATAL's helpline has served tens of thousands Israeli citizens from every part of the country – almost 0.5 % of the population. Terror and war affect every citizen, directly or indirectly exposed to them (Tamir & Haimov, 2005; Keinan, 2012), and therefore NATAL's helpline serves large and diverse populations. Yet, recognizing and understanding the demographic characteristics of the callers may help adjusting and adapting the service to better suite the needs of the population. Watson, McDonald and Pearce (2008) maintain that a better understanding of the origin of calls to telephone counselling services could provide information that will allow such services to better cater to the needs of their clients. Yet, phone interventions' main advantage is the anonymity they offer. Identification of callers is often inappropriate (Campos, 2009). Asking for information is usually intimidating to callers and might cause them to hang-up the phone. More than that, usually people call helplines in times of need/crises – they want to vent, to be understood, to be listened to and to receive assistance (Tamir & Haimov, 2005; Gelkopf, Haimov & Lapid, 2015). They do not want to be asked questions or provide information. They don't want to be bothered with what they feel is irrelevant and unimportant at their critical situation. Therefore obtaining data regarding callers to helplines is a very challenging task.

Despite the difficulty to obtain data from callers, the aim of this part of the study is to gain more insight in characteristics of Natal's callers. An appropriate and elaborative description of the characteristics may help:

a) To better understand the needs of callers and their reasons for calling, in order to provide appropriate response.

b) To identify vulnerable in-need of assistance populations, so that more attention and resources may be directed their way.

c) To identify populations which are less likely to seek help and therefore need services to reach out to them.

Demographic data

NATAL's helpline callers

At NATAL's helpline, during the first contact, we try to almost completely avoid asking the callers for factual information. Demographic data of the caller is gathered to varying degrees, depending on the willingness of the caller to give such information: sometimes callers freely disclose such information, other times the information will be gathered slowly and over time, and sometimes such information will remain unknown to NATAL.

The information-gathering system was designed to collect whatever information was necessary to make an appropriate intervention. It was not designed to collect data per se.

The information-gathering strategy is as follows. First, calls are documented by the specialists as they come in. The most relevant demographics of the caller are noted i.e. gender, age, and marital status.

Gender is usually perceived from the caller's voice (not only distinguishing between male and female voices, but also in Hebrew verbs are used differently by a male or female speaker). Data regarding the gender of the caller is recorded in every case at the helpline.

Age is also detectable, to some extent, in a caller's voice. Age is asked when appropriate and approximated if the caller is unwilling to provide this information. If the caller's age can't be assessed yet the specialist finds it to be crucial to understanding some aspect in a specific case, then the specialist tries to obtain that by saying: "you sound very young", "you seem to be very mature, I don't know if it is your age or your experience", etc., sometimes the specialist will directly say: "may I ask you about your age so I can better understand your situation?".

Data regarding callers' age isn't always available. In most cases it is either estimated or retrieved from the caller and then it is recorded in the case file. Although this data is incomplete, since most cases include information regarding the callers' age, I believe the data collected is reliable and can be used to characterize the helpline callers.

Data regarding callers' marital status is based upon information received directly from the callers. This recorded data is very reliable and accurate – almost all case files contain that

information. It is possible to ask callers for such information through inquiring about their support system, usually by asking: "do you have someone close you can share these feelings with?", "it is important to share what you are going through with someone so you don't have to carry the burden alone – do you have family or friends you can talk to?", etc.

Also noted are the problem(s) reported and the causality (the incident that led to the call):

The categories "War" and "Terror attacks" refer to callers suffering from problems resulting from wars and terror attacks. These can be psychological problems and/or other problems (e.g. financial problems). Sometimes these callers contact the helpline immediately after the event and at other times they might contact the helpline months or years after the traumatic event – as long as they indicate a specific war or terror attack that led to their suffering, they will be included in one of these categories accordingly. Another diverse aspect of this category is that it includes civilians and soldiers alike, which reflects the effect of terror and war on vast populations.

Dissimilarly of the former category, "Military service" includes only soldiers that were injured and/or traumatized during their mandatory military service. These soldiers contact the helpline only after they were released from military service since as long as they are in active duty they are not allowed to seek psychological assistance outside the military. It is important to clarify that soldiers who fought a war during their military service will be included in the category of war and not in the category of military service

The categories "Security problems" and "National event" are only used in crisis situations: Security problems usually indicate sudden missile attacks (not during a war or military operation), threatening announcements of neighboring Arab leaders that cause alarm/panic in the Israeli public, security forces warnings regarding potential hostile attacks etc.

National events are happenings unrelated to terror or war, yet are magnanimous enough to have national public impact (e.g. forest fire that killed tens of citizens, an earthquake in another country that killed many Israelis).

The category "Unidentified" includes events of smaller scale that might be less known to the general public or couldn't be specifically recognized by the specialist. These can be either terror attack that affected only individuals (e.g. throwing of stones) or military actions that also affected only individuals, or actions which were classified.

The category "Unrelated" includes callers who experience problems unrelated to trauma of war and terror. They call when they are in crisis and are usually referred to other services.

Every call to NATAL's helpline is recorded through a computerized system which provides statistics regarding the helpline activity. This computerized system was developed specifically for NATAL's helpline and went through adjustments and adaptations over the years. It stores valuable data of every caller to the helpline, from opening day at 1998 to this day.

NATAL's helpline clients

During the initial call, the specialists make a preliminary assessment of the caller's situation, needs and his/her available resources. When a caller appears to need more than crisis intervention and the specialist evaluates that the caller can benefit from the helpline as a resource, then that caller is offered the opportunity to receive a longitudinal intervention. A person is considered the *helpline client* when they receive an intervention that lasts more than a month and more than 4 conversations.

When a person becomes a *helpline client*, it is indicated in the computerized system in order to enable follow-up and comprehensiveness of care. This indication enables the helpline staff to have immediate access to crucial information (e.g. the specialist who is assigned to the specific case, whether the caller receives psychotherapy).

Demographic data of clients is recorded since the first call to the helpline (they are then considered *helpline callers*), and is updated throughout the helpline intervention.

This research presents quantitative information from 1998 till 2015 (December 31st). After obtaining NATAL's CEO permission, demographic data was extracted from the computerized system by the helpline administrative manager. This data was then analyzed in order to gain as much insight possible regarding the characteristics of callers and clients.

Demographic data of callers and clients will be provided and compared, yet this study will focus on callers to the helpline that became clients – after their initial call to the helpline they received longitudinal phone interventions at NATAL's helpline.

NATAL's helpline interventions

Before describing the methodology used to assess the helpline interventions, it is important to note that NATAL's primary commitment is to its clients. The well-known Hawthorn effect (McCarney et al., 2007) which indicated that subjects modify their behavior, in response to their knowing that they are being studied, has suggested that field research methodologies may interfere in treatment procedures. This is something I wanted to absolutely avoid. I was concerned by the fact that the callers who are interested in developing a therapeutic relationship through the telephone would possibly be especially sensitive to issues of control, anonymity and stigma. It is extremely difficult to perform a classical research study in the context of the helpline intervention due to the fact that telephone interventions are very different from usual treatment interventions in that they are usually anonymous and that it is always the client who has control over the agenda discussed during the phone conversation. The specialist is in no position to request a questionnaire or clinical assessment of the client (his/her condition). Furthermore, from experience it is clear that setting time apart for a research oriented interview during treatment or a request to participate in a study is counterproductive and would only hamper the therapeutic relationship.

Since usual interviews couldn't be performed and questionnaires couldn't be administered, it was necessary to use a none-direct and non-invasive assessment procedure. To overcome this hurdle a research methodology was developed that did not interfere in the therapeutic process, yet will still provide a good understanding of the population served and the impact of the intervention while possibly improving the service provided. This is in line with qualitative content analysis methodology.

Therefore, with the assistance of NATAL's research unit, a four-phase research approach was planned.

1) First, in cooperation with the helpline team, we developed a battery of scales that included items developed for this study in addition to well-established assessment tools:

   Based upon the information that is known to reside in the clients' files, we built a list of questions aimed at receiving information regarding demographic data, reasons for calling, help seeking history, social support, type of phone intervention, reasons for ending the intervention, functioning and posttraumatic symptomatology. For both functioning and posttraumatic symptomatology the questions assessed status at the beginning of the intervention and at the end of the intervention. The list was set up as a short judge-rated questionnaire for the purpose of quantitative analysis to be used when assessing clients' files.

2) Telephone specialists were trained to be aware of the importance of functional assessment and of symptomatic assessment of clients, and to gently request the information, only if it did not interfere with the therapeutic process. They were instructed to avoid giving the impression of it being a clinical or a "list" assessment and to record it in the client's file.

3) Following the therapeutic session, telephone specialists wrote down a detailed report as much as possible and verbatim of the session, including the different dimensions featured in the battery – this was done for regular weekly supervision purposes in a semi-structured 2–4 pages format.

4) After the therapeutic relationship at the helpline was ended data was gathered from clients' files (files contain the summarized near-verbatim content of each telephone session) by a trained research assistant who is also a telephone specialist. The research assistant analyzed the content of the conversational exchange of the recorded sessions, and on this basis filled in a questionnaire by-proxy. Inter-judge reliability of the questionnaire was validated based upon a sample of 20 test cases and was found to be good.

The research design was approved by the ethics committee at the University of Haifa, Faculty of Social Welfare and Health Sciences.

Characteristics of the intervention

Elements of the phone interventions were grouped to categories based on the type and the characteristics of the intervention performed by the phone specialist. The categories are:

a) Guidance - guidance in helping others, i.e., guiding parents in assisting their children, guiding clients in assisting their spouses, guiding children (mostly adults) in assisting their parents.

b) Self-help tools - self-soothing, visualization, relaxation, self-talk, behavioral and cognitive methods.

c) Community connectedness - assistance in setting up a connection with health, social and legal assistance agents.

d) Stress-related emotional ventilation - encouraging clients' emotional expression, talking out problems and tensions.

e) In-depth therapeutic intervention - in the form of trauma-focused dynamic, behavioral or cognitive intervention.

f) Psychosocial education - the provision of necessary explanatory information regarding traumatic reactions and processes.

The characteristics of the interventions themselves were firstly explored in order to assess the outcomes of the helpline interventions.

The outcomes of the intervention

In order to discover whether the helpline interventions are indeed beneficial to the clients, it might be important to assess more than just clients' satisfaction. Although the contentment of the clients is important and desirable, it might not be sufficient – by offering the longitudinal intervention, the aim is to provide more than just containment and empathy. Different therapeutic approaches are used with the intention of improving clients' quality of life.

All of the helpline clients suffer from symptoms related to trauma or loss, and to some degree their functioning level in different aspects of life is hampered. Therefore, if clients improve on symptoms level and/or functioning level, then it can prove that their quality of life was improved.

Functional problems

The assessment of functional problems was based on eight functional dimensions (Gelkopf & Berger, 2009): (1) daily functioning, (2) functioning at home, (3) functioning as a parent, (4) functioning as a spouse, (5) social functioning, (6) vocational functioning (or in studies or leisure), (7) sexual functioning, and (8) drugs or alcohol related functional problems.

Based on the information on each client's file, the research assistant made an assessment regarding the functioning of the client. Functional problems were defined as absent (score=0), moderately (score=1) and significantly present (score=2). Then, a functioning score on a scale of 0–16 was calculated.

In order to get as much accurate information as possible, the problems in each of the functional domains were verified in the first five sessions and in the last five sessions of the longitudinal intervention. It is important to note that as part of the closure process of the intervention, the specialist and the client usually reflect on the progress made during the longitudinal intervention – it is a process of remembering the initial sessions and the problems presented then, and relating that to

the end-point of the intervention, discussing the present situation, the problems still existing and future plans to cope with them. This process enables the specialist to get an accurate assessment regarding the client's situation. It also enables the research assistant to gather information that is based not only on their impression or the specialist's impression – it also provides the client's self-report – which is invaluable information.

Functional assessment was introduced at the helpline in 2007, and most of the reliable data is from 2008 onwards (it took about a year to train the specialists, follow-up on their work, making the necessary adjustments until full implementation of this process at the helpline).

Post-traumatic symptomatology

The assessment of symptomatology was introduced at the helpline in 2007, in conjunction with functional assessment.

Dissimilarly to functional assessment, the design of the assessment of symptomatology has been changed several times: initially there was an assessment of the change in the presence of the symptoms. The purpose was to find out if the intervention led to some changes in symptomatology and to ascertain that it didn't worsen the clients' symptomatology. After a year of such assessment it showed that no client (0%) showed deterioration of symptoms level and only 14 clients showed no change. Almost all the clients (93%) showed changes in symptomatology. Yet it was realized that although this process showed that there is dynamism in symptoms levels during the intervention, it didn't provide the understanding whether there was an improvement in symptomatology. This realization led to a change in the assessment design.

Another change that was made in the assessment design resulted from the understanding that there was a focus on post-traumatic symptoms yet symptoms typifying to loss weren't incorporated.

Due to the changes made in the assessment design, the reliable data is from 2009 onwards.

To assess post-traumatic symptoms (PTS), a modified version of the (PCL-C) Post-traumatic Check List Civilian version (Weathers, Litz, Herman, Huska & Keane, 1993; Weathers & Ford, 1996) was used. The PCL-C contains 17 items originally, to which four bereavement-related symptoms (total of 21 symptoms) were added.

Each symptom was assessed as major problem (score of 1), as mild or absent (score of 0). A symptoms score on a scale of 0–21 was calculated.

In order to get as much accurate information as possible, the symptoms were verified in the first five sessions and in the last five sessions of the longitudinal intervention

This research presents clients' data from 2010 till 2014. Data collection was gathered in 2015-2016. Since some of the data exists only from 2009, in order to observe any intervention containing sufficient information regarding clients, then data could be collected only a year after the intervention started (meaning 2010).

One hundred closed cases were randomly chosen from each year (2010-2014). From the 500 cases that were reviewed, 438 cases contained sufficient information regarding functional problems, and from those only 142 cases contained sufficient information regarding post-traumatic symptomology.

Qualitative methodology

'By three methods we may learn wisdom: First, by reflection, which is noblest; Second, by imitation, which is easiest; and third by experience, which is the bitterest'.

Confucius

(Fingarette, 1998)

There are a wide variety of methods that are common in qualitative measurement (Denzin & Lincoln, 2002; Holloway, 2005; Silverman, 2013). This research involved some of the most common qualitative methods such as in-depth interviews, focus groups and personal records/case files. The use of several different methods was targeted at achieving rich and varied information, since each method is particularly suited for obtaining a specific type of data (Bassett, 2004; Pope & Mays, 2013).

Focus groups

Since the introduction of focus group interviewing by sociologists in the 1950s, it has been widely adopted by marketing researchers interested in people's perceptions of products, as well as by social activists attempting to understand the needs and problems confronted by various constituencies in the community (Denzin & Lincoln, 2002; Holloway, 2005).

Participants typically form a relatively homogeneous group of 6 to 12 people, with a professional moderator setting the tone for the interaction, asking broad questions of relevance to the study, and facilitating the group dynamics which result (Patton, 1987). Focus groups can therefore be an efficient way to increase the number of participants in a qualitative study, yielding recorded conversations that can be subjected to closer analysis (Bassett, 2004; Pope & Mays, 2013). They are not, however, without their drawbacks, as the constraints imposed by spending an hour or two with a group of perhaps eight or ten people obviously precludes a very personal or detailed exploration of the views or experiences of any one of them (Rubin & Rubin, 1995; Neimeyer & Hogan, 2001).

Focus groups are effective in eliciting data on the cultural norms of a group and in generating broad overviews of issues of concern to the cultural groups or subgroups represented (Denzin & Lincoln, 2011; Silverman, 2013).

Interviews

Interviews are optimal for collecting data on individuals' personal histories, perspectives, and experiences (Denzin & Lincoln, 2011; Silverman, 2013). Interviews can be structured, unstructured or semi-structured.

Structured interviews are carefully worded questionnaires and don't allow much scope to deviate from it. Unstructured interviewing involves direct interaction between the researcher and a respondent or group. It differs from traditional structured interviewing in several important ways. First, although the researcher may have some initial guiding questions or core concepts to ask about, there is no formal structured instrument or protocol. Second, the interviewer is free to move the conversation in any direction of interest that may come up.

Consequently, unstructured interviewing allows more exploration and deviation in its approach, which is particularly useful for exploring a topic broadly. However, because each interview tends to be unique with no predetermined set of questions asked of all respondents, it is usually more difficult to analyze unstructured interview data, especially when synthesizing across respondents (Holloway, 2005; Bassett, 2004; Pope & Mays, 2013).

Personal records

Personal records/case files are first-person accounts of events and experiences. As qualitative gathering of information, personal documents can help the observer to gain insight of the participant's world (Shlasky & Alpert, 2007).

The qualitative part of this research was done using several different resources. Here is a description of the resources.

The main research question was 'how do phone interventions (according to the LIM) help callers and clients at the NATAL helpline?'

The target of this research is to try and gather information which can provide an answer to this research question from two main perspectives: the first is the callers and clients point of view. The data collected in that regard aimed at discovering what callers/clients say during and after the phone intervention, that can indicate to what they find helpful. The second perspective took the angle and standpoint of the helpers/the helpline specialists. The data collected in that regard aimed at discovering what are the callers'/clients' characteristics, which problems or struggles they present, and the observed changes in those problems during and after the phone interventions. Also, it is

important to find out the helpers perception of what is helpful to the callers/clients in order to compare these two perspectives and learn from that.

The qualitative data from the perspective of the callers and clients was mainly gathered from their personal records/case files and from 'thank you' letters that they sent to the specialist/helpline. Additional information was achieved from three in-depth interviews with the helpline clients, as part of their farewell process leaving the helpline at the end of the intervention.

The qualitative data from the perspective of the helpers/specialists was mainly gathered from focus groups and in-depth interviews with them.

The field work and data collection was gathered in 2015-2016.

Based on the research questions, four domains were developed as an initial list of topic areas. The four domains are; clients' situation, the intervention, the helping process, and the relationship with the helper/specialist. I reviewed the different sources of data (case files, 'thank you/closure' letters, personal interviews, and focus groups) independently. The documents and transcribed interviews were read several times to sort all material that related to the same idea into domains. The next step was reading the raw data within each domain and formulating categories.

Clients' case files

Clients' case files were used for both the quantitative and the qualitative gathering of information.

The qualitative data was gathered from the 438 cases which were reviewed and found to contain sufficient information for the quantitative analysis, thus providing a connection between the qualitative data and the quantitative data, and allowing triangulation.

A content analysis of the conversational exchange of the recorded sessions was made to find references of clients to their situation, the intervention, the helping process and the relationship with the helper/specialist. The verbatim content was extracted from these recorded sessions and the data was grouped to these four categories. Data which was found to be reoccurring and thus might be important was recorded separately, and was reviewed at a later stage of the research. This allowed unexpected material to emerge.

This is in line with content analysis approach. Content analysis, which originated from sociology and psychology, is a hybrid method with qualitative and quantitative features (Gottschalk, Lolas & Viney, 1987). Unlike grounded theory analyses, in which researchers attempt to minimize their preconceptions regarding the phenomenon of interest, content analysts often approach a text with a formal categorical system in mind and then code material (e.g., interviews) in light of those categories. In most instances, the fundamental data consist of the frequencies of occurrence of each code, rendering the results amenable to quantitative summary or comparison with other measures provide a good overview of content analytic methods (Neimeyer & Hogan, 2001).

Interviews of three clients

A story that is told in a research interview is a co-constructed product of the interaction, as it is in therapy. Researchers need to be acutely sensitive to their role in shaping the telling and in shaping the story that is told (Romanoff, 2001).

Romanoff (2001) also suggests that in the conduct of narrative research, the lines between therapy and research blur. The process of answering the researcher's questions changes the answer as participants construct their story anew. In actual practice narrative therapy is investigative research, and interview research is often therapeutic (Romanoff, 2001).

During 2013-2015, there was an attempt to offer helpline clients a closing session at the end of the longitudinal intervention. The helpline management and the helpline specialists noticed that clients who received long-term assistance at the helpline were having difficulties with ending their relationship with the specialist/helpline.

The closing process at the end of the intervention, according to the LIM, consists of about four closing sessions, during which the client and the helper reflect on the clients' situation at the beginning of the intervention and the end of the intervention, and discuss the journey they went through which led to that point. The goal is to help clients acknowledge the progress they made, to reflect on their efforts, strengths and resources which brought about this progress, and to realize their ability to continue their journey independently.

During 2013-2015, Clients were offered the opportunity to have a closure procedure – either to send and receive closure letter to and from the specialist who manages the case, or to have a closure session, where they are videotaped by an interviewer (a helpline specialist who didn't manage that same case). The closure procedure allowed them to review their lives, before and after the

trauma/loss, so that they can weave a coherent narrative/life story. It also included a reflection on the process at the helpline and the relationship with the helper. Letters were written and sent by both parties, keeping copies attached to the case file. After the closure session, the clients and their specialist received a copy of the video. Both the letters and the video serve as a parting gift.

All the clients who participated in this process signed a consent form allowing the organization to use it for research and learning purposes.

As the helpline director, I took an active part in this process, and a few times took the role of the interviewer. The clients were informed that I am a part of the professional staff of the helpline (which was routinely involved in the interviews), so that my formal managerial position will not intimidate or interfere with the interview.

For the purpose of this research, although consent was already given by the clients, I contacted three former clients who were interviewed by me in 2014 and asked their permission to use their video and data in my research. Their verbal consent was received and audiotaped.

One of the interviews lasted two hours, another lasted two and a half hours and the third lasted three hours. Then they were transcribed and analyzed to ensure that emergent themes remained grounded in the data.

These interviews with clients are invaluable to this research for several reasons. First, as all helpline clients, they are invisible and anonymous – but through this process they become physically visible. Secondly, it provides a unique opportunity to hear directly from the clients their perspective regarding the phone intervention, the specialist who helped them and the LIM. The fact that the interviewer isn't the specialist who managed the case provides more accuracy and less biased responses. Thirdly, as Romanoff (2001) suggested, the goal in narrative research is the understanding of human behavior and meaning. These interviews ask the research participants to educate us about their lives, about their coping with the trauma/loss, and about the process of help.

Clients' closure and 'thank you' letters

As described above, closure letters are part of some of the clients' files. Whenever a 'thank you' letter is received, it is also kept attached to the case file.

Out of the 438 case files which were included in this research, 12 letters were available to be included here – seven 'thank you' letters and five closure letters.

A content analysis of the letters was made. The verbatim content was extracted from these letters and the data was grouped to the same four categories (their situation, the intervention, the helping process and the relationship with the helper/specialist).

Focus groups - specialists

Two focus groups were held for the purpose of obtaining the helpers/specialists' perspective.

I compiled a list of possible voluntary staff from the helpline that I know to be reflective and interested in better understanding their work (some are active volunteers and some are non-active volunteers), and asked them to take part in the research.

All the participants knew that I was working on a PhD research before they were contacted -they heard it from someone at the helpline or directly from me.

Each participant was sent an invitation to the focus group through a text message and confirmed their attendance with a text message.

I arranged the list in an order of their seniority at the helpline. After receiving their confirmation I arranged the groups so each group will include diverse participants.

The participants in both groups know each other and have worked together in the past, but they don't have close ties, they were trained in different courses, and they have different seniority at the helpline.

I have a good relationship with every participant based on the training I provided them and the intimacy and openness it required. I have worked with all of them in group settings many times before, and also had individual meetings with them. The process of me asking them to reflect on their work at the helpline is very familiar to them and that allows for a speedier process during the focus group.

The focus groups were held at the private homes of 2 of the participants in the intention of promoting an informal and comfortable atmosphere that can enhance the openness and frankness of the participants. To that end they were also offered coffee and cake upon arrival.

The 2 small size focus groups were conducted using a topic guide. The participants were given a description of the background of the study, including the purpose and importance of developing better understanding of phone interventions and the unique model - the LIM. The focus group was introduced as an open discussion with the aim of exploring three main topics: the helpline impact (what are the characteristics of callers and clients / which population is affected by the helpline?), the therapeutic process (what are the characteristics and the effect of the intervention?), and the therapeutic outcome (does the intervention improve clients' health and well-being). The open

discussion that was based on a topic guide with prompts allowed the discussion to focus on the main topics while also allowing flexibility to follow up issues that emerged.

As Romanoff (2001) suggested, broad and semi-structured questions were presented to the participants, with an attempt not to impose the researcher own constructions on the interviewees' experiences, so that the data collected in this manner can best represent the participant's truths.

The first focus group included 5 voluntary staff. The focus group discussion lasted approximately 4 hours. The second focus group included 5 voluntary staff. The focus group discussion lasted approximately 4 hours.

The participants' responses were videotaped and audiotaped with participants' consent. Then the sessions were transcribed and analyzed to ensure that emergent themes remained grounded in the data.

It was found that videotape and audio recordings, where ethical, are very helpful. These methods are not subject to bias in terms of what behavior gets recorded and what does not (Guba, 1981; Erlandson, 1993; Morse, Barrett, Mayan, Olson, & Spiers, 2002).

An analysis of all the resources; transcribed focus groups and interviews, case files, and closure/'thank you' letters resulted in the identification of many themes and patterns of significance which emerged through this data analysis process. Themes and categories were developed until they approached saturation, or the point at which themes and categories became repetitive. Towards the end of the study no new themes emerged, which suggested that major themes had been identified. Only when all the evidence from the documents and interviews created a consistent picture of the way in which phone interventions (according to the LIM) help callers and clients at the NATAL helpline, were the processes of data collection and analysis complete.

In the next part, the results of the study are presented. The first chapter presents the results attained through quantitative methods, and the second chapter presents the results emerged through qualitative inquiry.

PART VI

Results

Chapter 10

Quantitative Results

'Judge a man by his questions rather than his answers'.

Voltaire

(Voltaire, 2004)

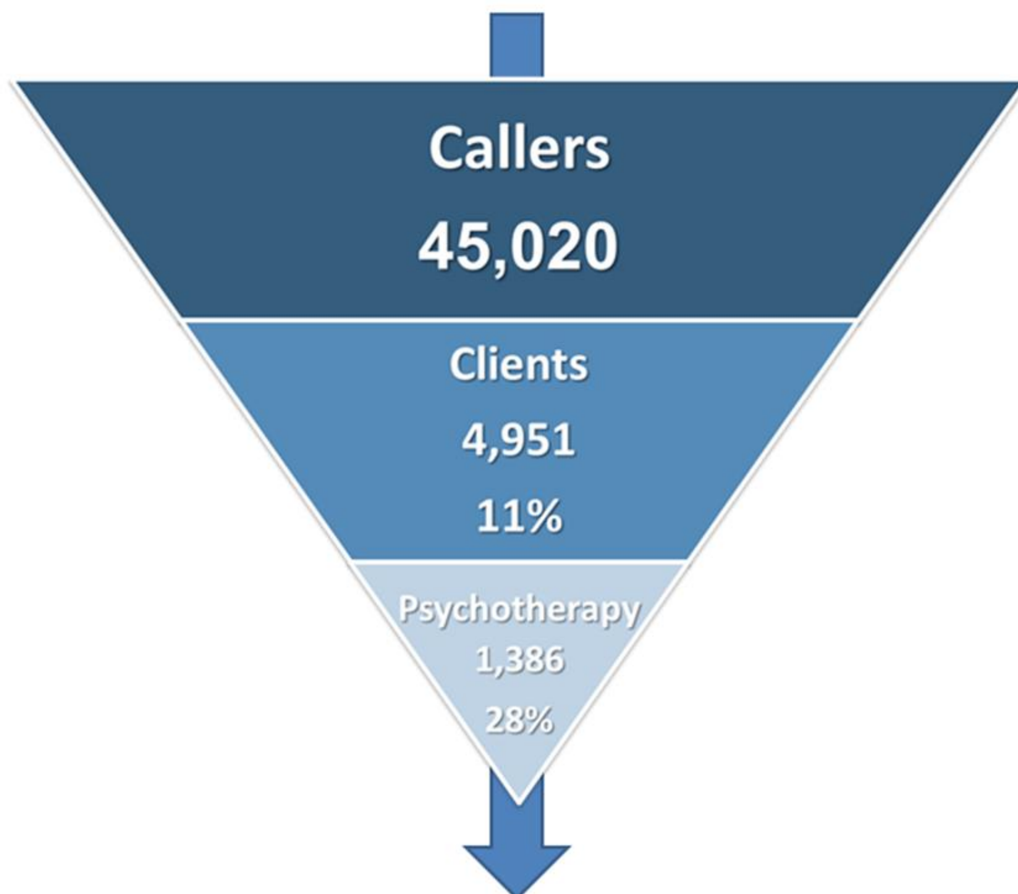
The helpline impact

Incoming calls to NATAL's helpline

The aim of this study was to find out how phone interventions (according to the LIM) help callers and clients at the NATAL helpline. The first step was exploring the information concerning the calls to the helpline.

During the 17 years of its existence, NATAL's helpline has served tens of thousands Israeli citizens from every part of the country – 0.5 % of the population.

Table 1 – Incoming calls to NATAL's helpline



This data outlines the scope and pattern of calls received at NATAL's helpline: during the 17 years of its operation, it received 45,020 incoming calls.

11% of these callers became the helpline clients – that is they received an intervention that lasted more than a month and more than 4 conversations.

After the helpline intervention, 28% of the helpline clients are willing to accept additional professional help and are referred to psychotherapy.

Causality - reason for calling

The main reason which led the caller to contact the helpline is documented, and classified within one of seven categories.

Table 2- Causality - reason for calling

Wars	**40%**
Terror attacks	**13%**
National event	**10%**
Military service	**8%**
Security problems/Missiles attacks	**7%**
Unidentified	**7%**
Unrelated	**15%**
Total number of calls	**45,020**

The data presented in Table 2 demonstrates that the largest group of callers who contacted the helpline was people seeking help due to one of the wars (40%). Terror attacks are responsible for 13% of the calls (second largest group).

Routine and emergency

NATAL's helpline operates during routine times and also during emergencies/national crisis situations.

In order to better understand the data of callers to the helpline, it is important to distinguish between routine calls (which may or may not lead to additional interventions) and crisis calls (which usually will not lead to additional intervention).

The data presented in Table 2 can also assist us in calculating the amount of crisis/emergency calls: the categories "Security problems" and "National event" are only used in crisis situations, therefore, 10% of the calls that are due to National event + 7% of the calls that are due to Security problems, which equal 7,653 calls are crisis calls.

Other crisis calls are received by the helpline during wars and terror attacks. Yearly analysis of the calls shows that 30% of the calls defined as belonging to the categories of wars and terror attacks are received during emergencies. Thus, to calculate these numbers we add 40% of calls due to war to 13% of calls due to terror attacks – the 53% of the calls equal 23,861 calls, of which 30% are crisis calls. Therefore, it is reasonable to assume that about 7,158 of these calls are also crisis calls.

Another relevant figure to this calculation is the number of unrelated calls (callers experiencing problems unrelated to trauma of war and terror, who call when they are in crisis and are usually referred to other services). Table 2 shows these are 15% of the callers, i.e. 6,753 calls.

This leads to the final estimated number of crisis calls: 7,653 (security situation and national events) + 7,158 (30% of war and terror calls) + 6,753 (unrelated calls) = 21,564 crisis calls.

This figure reveals that crisis calls are almost half of the calls the helpline receives: 21,564 is 48% of the 45,020 incoming calls. That also means that 23,456 are non-emergency calls.

In order to gain better understanding of the helpline operation and the characteristics of the calls and callers at the helpline, it may be beneficial to study the pattern and numbers of calls to the helpline.

Tables 3-5 present the incoming monthly calls to NATAL's helpline in the years 1998-2015. These tables also specify events which may influence the number of calls (e.g. war, terror attack, media campaign).

Table 3 - Incoming monthly calls 1998 - 2003

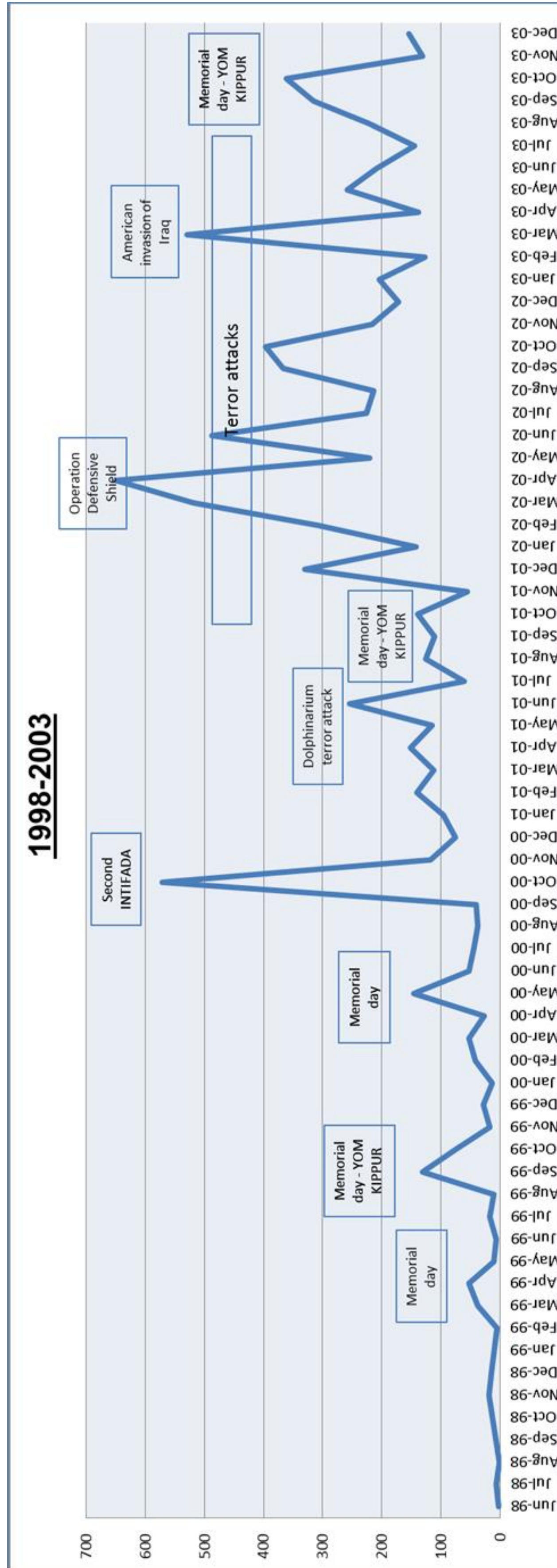


Table 4 - Incoming monthly calls 2004 - 2009

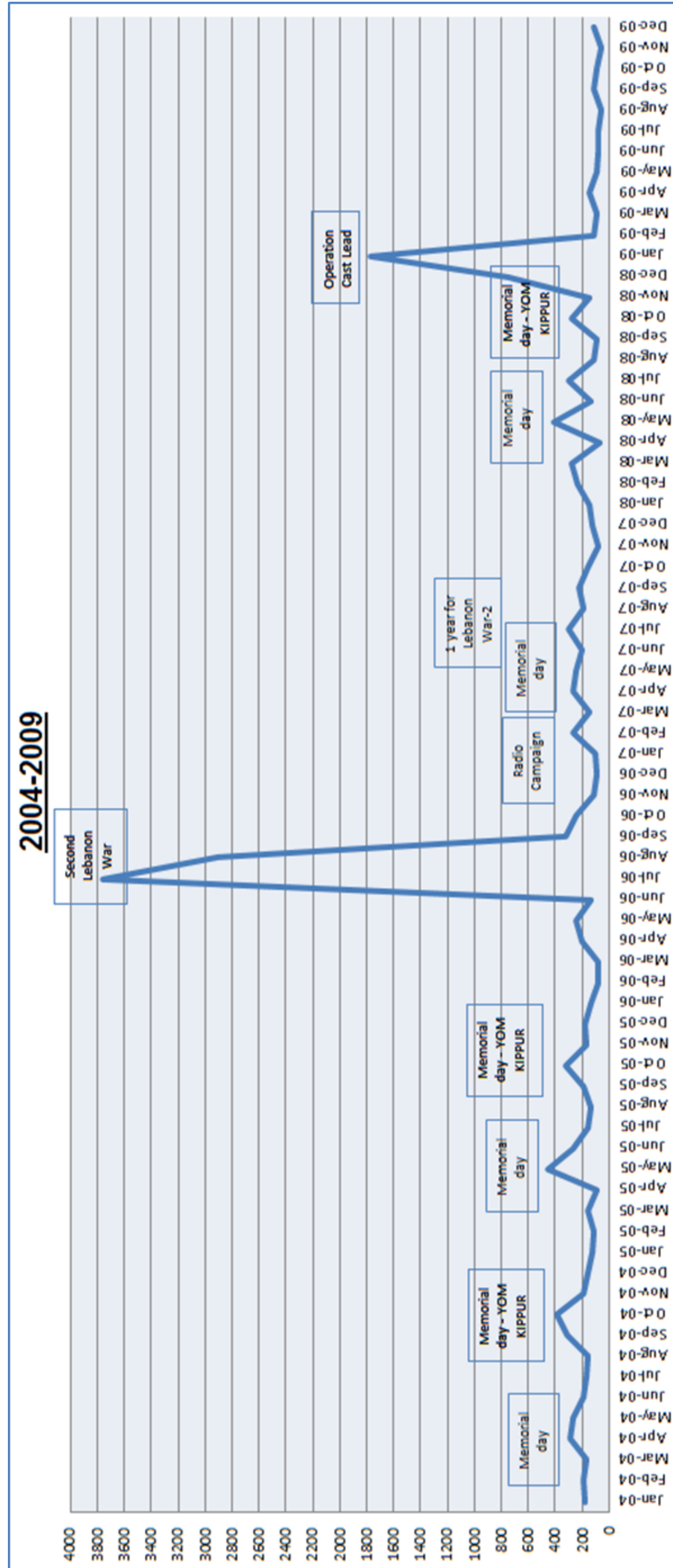
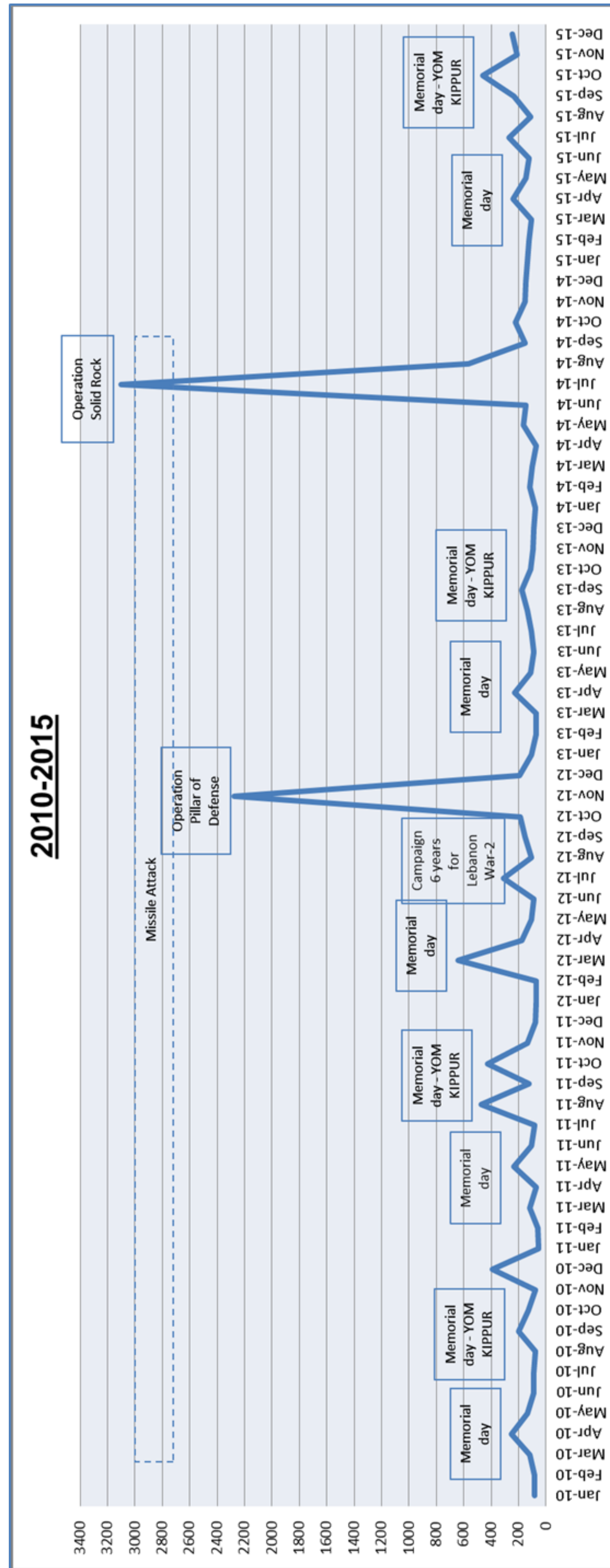


Table 5 - Incoming monthly calls 2010 - 2015



Tables 3-5 show that there is an influence of traumatic events on the number of incoming calls to the helpline. Some events, such as memorial days or media campaigns, bring about more incoming calls than routine (non-eventful) months. Other events, such as wars and military operations instigate a significant increase in the number of the incoming calls.

During routine times, most of the callers to the helpline are people suffering from trauma or loss, which cannot cope well with the emotional distress they carry, and consequently they call the helpline seeking help. Most of these callers will need additional assistance, thus they become the helpline's clients.

Table 6 (similar to Table 1) shows the pattern of the routine calls:

Table 6 – Incoming routine calls to NATAL's helpline

This finding is important for the understanding of the ratio of callers who become clients: out of the 23,456 non-crisis calls 21% become helpline clients. Differently than what is presented at Table 1, which show that 11% of the callers become the helpline clients, this table consider more factors, such as the type of calls, thus enabling a more specific and accurate calculation.

Callers vs. Clients

The number of callers is different than the number of calls, in that there are callers who contact the helpline more than once. Table 7 shows the number of callers per year in the period of 1998-2015.

Table 7 – Number of callers per year

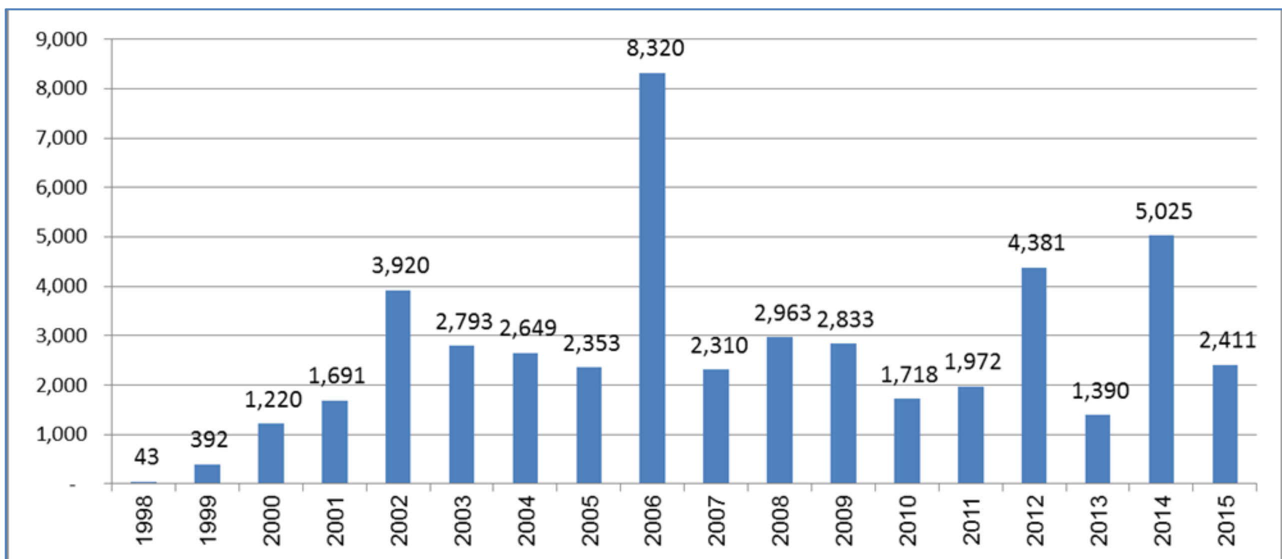
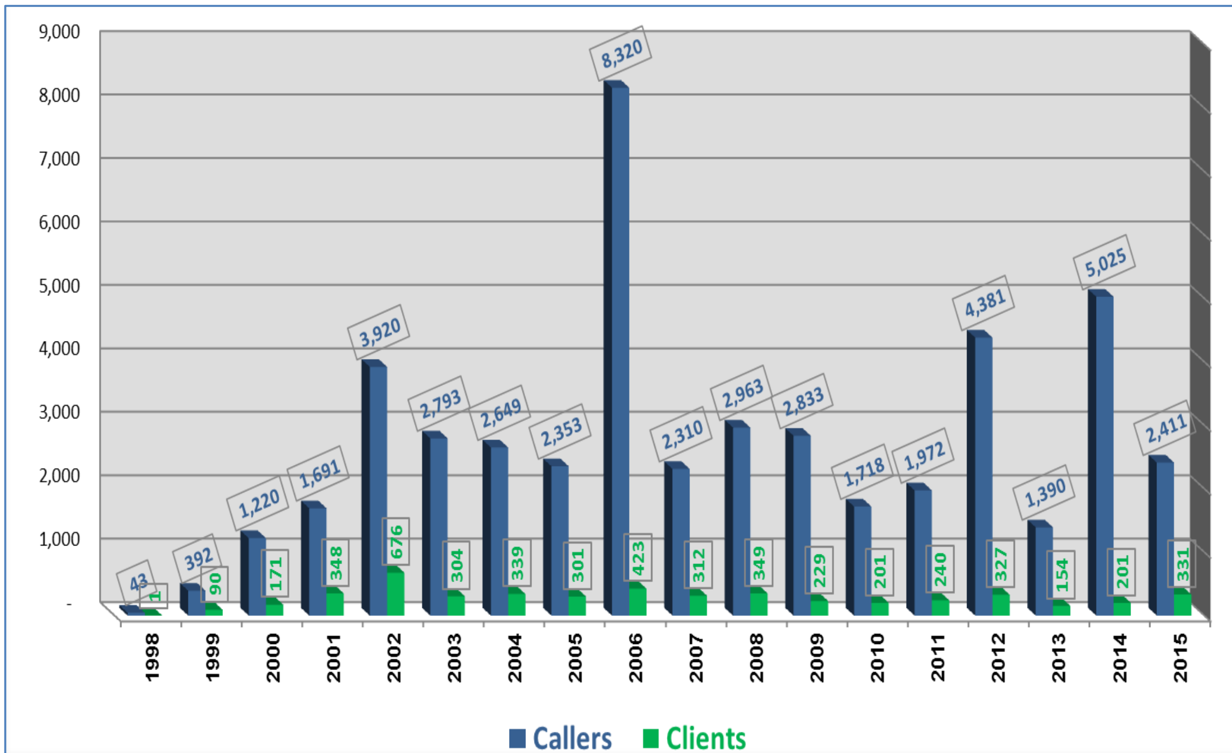


Table 7 demonstrates that since the establishment of the helpline in 1998 the largest number of callers was in 2006, when 8,320 callers contacted the helpline. The second and third large numbers of callers are in the years of 2014 (5,025 callers) and 2012 (4,381 callers).

The data shown in Table 7 reveals that the average yearly number of callers to the helpline is 2,688. It also exhibits that there is similarity in the number of callers in many of the years, which is around 2,000 callers.

The results of the numbers and pattern of the yearly helpline callers are worth being compared to the numbers and pattern of the yearly helpline clients (Table 8).

Table 8 – Number of Callers vs. Clients per year



The research hypothesis is that the yearly number of clients will be positively related to the yearly number of the callers to the helpline. To test that hypothesis, a Pearson's correlation test was conducted.

The results show a strong positive correlation between the two variables: ($r=0.58$, $p<.01$).

Demographic Data

Table 9 – Demographic data of Callers vs. Clients

Gender	Callers	Clients
Female	**58%**	**43%**
Male	**42%**	**57%**
Age group	**Callers**	**Clients**
6-18	**5%**	**3%**
18-35	**22%**	**22%**
35-50	**27%**	**30%**
50-75	**40%**	**40%**
75+	**6%**	**5%**
Marital status	**Callers**	**Clients**
Married / Unmarried partners	**55%**	**61%**
Single	**26%**	**22%**
Divorced/ Separated	**13%**	**12%**
Widowed	**4%**	**4%**
Single parent	**2%**	**1%**
Total	**45,020**	**4,951**

Demographic Data of callers

As can be seen in Table 9, the majority of callers (58%) are female.

This table also shows that the largest age group of callers is over 50 years old (40%), followed by adults between 35-50 years of age (27%). Children and adolescents (5%) and elderly above 75 (6%) call less often to NATAL.

Additionally, Table 9 shows that the majority (55%) of callers to NATAL's helpline is married or cohabits with their non-married partner.

Demographic data of clients

As can be seen in Table 9, the majority of clients (57%) are male.

This table also shows that the largest age group of clients is over 50 years old (40%), followed by adults between 35-50 years of age (30%). Children and adolescents (3%) and elderly above 75 (5%) become less often clients of the helpline.

Additionally, Table 9 shows that the majorities (61%) of the helpline clients are married or cohabit with their non-married partner.

The comparison between callers and clients in Table 9 shows that there is a difference in the demographic characteristics of NATAL's clients versus NATAL's callers with regards to gender. While 58% of the callers are female, only 43% of the clients are female.

A Chi-square test was conducted, and showed a significant difference of gender between callers vs. clients: $\chi 2(1, (N=49,442)=411.2, p<.001$.

Table 9 also demonstrates similar trend of the marital status of the clients compared to the callers, in that the majority of them are married. Yet, there is a significant difference in that while 55% of the callers are married, this characteristic is much stronger with clients, which 61% of them are married.

There are no significant differences in the age groups of the helpline callers vs. the helpline clients.

NATAL's helpline interventions

Table 10 demonstrates the different characteristics of the longitudinal interventions provided to the helpline clients.

Table 10 – Characteristics of the intervention

Psychosocial education	90.10%
In-depth trauma-focused therapeutic processes	58.40%
Stress-related Emotional ventilation	41.60%
Community connectedness	38.40%
Self-help tools	25.60%
Child guidance	15.50%
Spouse guidance	4.90%
Parent guidance	0.50%
Total numbe of interventions	**438**

As shown in Table 10, almost all of the clients (90.1%) received psychosocial education, and the majority of the clients (58.4%) received interventions that included in-depth trauma-focused therapeutic processes. Almost half of the clients (41.6%) received stress-related emotional ventilation, and 38.4% were connected to health, social and legal assistance agents in the community. 25.6% of the clients were given self-help tools.

A small number of interventions involved guiding the client in helping another person, such as child (15.5%), spouse (4.9 %), or parent (0.5%).

Further analysis of these interventions provides additional understanding of the therapeutic approaches applied by the helpline specialists – as described in Table 11:

Table 11 – Therapeutic main approach

Dynamic elements	23.30%
Cognitive elements	20.90%
Narrative elements	9.30%
Total numbe of interventions	**438**

The data shown in Table 11 indicates that the 2 main approaches which characterize the helpline interventions comprise of dynamic elements (23.3%) and cognitive elements (20.9%). Narrative elements are applied in only 9.3% of the interventions.

The outcomes of the helpline interventions

Table 12 shows the changes in the clients' problems after the helpline interventions.

Table 12 – Changes in clients' problems

	Beginning of intervention		**End of intervention**		**P value**
	Mean score	**SD**	**Mean score**	**SD**	
Daily Functioning N = 438	4.81	3.708	2.51	3.039	<0.001
Post traumatic symptoms N = 142	5.77	4.176	2.15	3.491	<0.001

As shown in Table 12, at the beginning of the intervention, out of the possible eight functional problems assessed, clients had on average a score of 4.81 (Sd=3.708) functional problems. At the end of the intervention, clients had on average a score of only 2.51 (Sd=3.039) functional problems.

A paired-sample T-test was conducted, and showed a significant improvement in symptomatic problems following the helpline intervention (t_{437}=17.65, p<.001).

Also, Table 12 shows that at the beginning of the intervention, out of the possible 21 symptomatic problems assessed, clients had on average a score of 5.77 (Sd=4.176) symptomatic problems. At the end of the intervention, clients had on average a score of only 2.15 (Sd=3.491) symptomatic problems.

A paired-sample T-test was conducted, and showed a significant improvement in symptomatic problems following the helpline intervention (t_{141}=11.77, p<.001).

It is important to emphasize that during the six years of this assessment only one client (less than 1%) showed worsening in symptomatic problems, and no (0%) client showed deterioration in functional level.

The helpline interventions showed significant results of therapeutic impact: there was a general decline in functioning problems, and an improvement in the severity of symptoms.

This study suggests that interventions done by the telephone specialists improved both the functional status, as well as the symptomatology status of the clients.

In conclusion, the results clearly show that indeed longitudinal telephone interventions can significantly improve both quality of life as well as functional status of clients suffering from trauma and loss.

Chapter 11

Qualitative Results

'In questions of science, the authority of a thousand is not worth the humble reasoning of a single individual'.

Galileo Galilei

(Galilei, 1997)

Research question

The main research question of this study was:

How do phone interventions (according to the LIM) help callers and clients at the NATAL helpline?

The questions that framed the qualitative part of the research were:

- The helpline impact (what are the characteristics of callers and clients / which population is affected by the helpline?)
- The therapeutic process (what are the characteristics and the effect of the intervention?)
- The therapeutic outcome (does the intervention improve clients' health and well-being?)

These questions were investigated from two perspectives - the perspective of the clients, and the perspective of the helpers/the helpline specialists:

The perspective of the clients

What do clients find helpful?

The perspective of the helpers/the helpline specialists

What are the callers'/clients' characteristics?

Which problems/struggles clients present?

What are the observed changes in those problems during and after the phone interventions?

What is the helpers' perception of what is helpful to the clients?

Qualitative results by categories according to research questions

The analytic procedure of the qualitative data entailed finding, selecting, appraising (making sense of), and synthesizing data contained in documents and interviews. The analysis yielded data—extracts and quotations—which were then organized into major themes, categories, and case examples (Breckenridge, Jones, Elliott, & Nicol, 2012). The categories were compared across interview transcripts (individual and focus groups), and data from documents (case files and letters) (Charmaz & Belgrave, 2002).

Here is a presentation of the qualitative findings. The categories are exemplified by quotes from different resources (Ryan & Bernard, 2003). Next to each citation there is an indication to the source of the extraction.

I - Clients' and specialists' interviews / **CF** - Clients' case files / **L** - Clients' letters / **FG** - Specialists' focus groups

The helpline impact (what are the characteristics of callers and clients / which population is affected by the helpline?)

What are the callers'/clients' characteristics?

- They turn to us in their most critical moments, in distress / they often show up with internal chaos, not knowing what is happening to them: "I am going crazy, I am abnormal" (FG).
- The sense of potency is broken – often this shows up with soldiers who – I could do anything and now I am a shattered vessel. There is a difference between the image of the strong heroic, brave capable soldier and how I feel now (FG).
- There is an internal feeling of "I cannot, anymore" or "this can't go on" - some experience of a dead end (FG).
- Most people come to us when they are at a crossroad or there is a trigger. A trigger can be an external event, like a terrorist attack, war or being called to reserve duty, but there are also known crossroads like retirement, divorce, birth of children (FG).
- The difficulty the callers have is to say that there is a problem at all - "The psychologist treats problems. I don't have a problem. I am just calling to get advice" (FG).
- Many times the people who call are in their minds – misunderstood, unseen, no one knows what they experience. With us this transparency disappears - we see them and suddenly they are no longer invisible (FG).

- Many times they don’t feel understanding or compassion from their family and friends. Even when they cry the family members are fed up seeing them cry. Although they have family, they feel very much alone (FG).
- Some people approached us under pressure or request from their family (FG).
- The helpline is an accessible service so clients can come in a weakened state; they don’t need as much strength. It is also a very flexible service (FG).
- The helpline is affordable – some of our clients can't afford treatment from an economic standpoint (FG).

Which problems/struggles clients present?

- Loneliness – clients say: "You are the only one I talk to" / "I don't share these things with anyone" / "I can only talk about these things with you" (FG).
- PTSD symptoms (sleep/nightmares, aggressiveness, agitation, flashbacks) (FG).
- Grief symptoms (sleep, detachment, preoccupation with loss, inability to experience joy) (FG).

The therapeutic process (what are the characteristics and the effect of the intervention?)

Six domains were identified by the participants, clients and specialists, as the characteristics and the effect of the intervention at the helpline. The domains are: creating a safe place, introducing new perspectives, providing guidance, emotional expression, providing understanding / empathy / containment, and the uniqueness of the medium – phone.

An additional domain was recognized by the clients - the unique characteristic of the LIM – reaching out.

1. Creating a safe place – specialists' perspective

- I have to create the safe place pretty quickly so that the client will stay with me (FG).
- They need us as an active listening ear (FG).

- I was just about the only person he had in the world / I was the only one she allowed herself to cry with (FG).

1. Having a safe place – clients' perspective

- I remember almost everything about the first conversation with the helpline: I talked a lot and felt that someone was listening. She said "I want to help ", "I understand ", "you are not alone", "Come closer-we are here for you", "if it is too difficult for you now then we can call you" (I).
- It wasn't easy to open up and share my story and my feelings. I agreed to give my phone number because she made me feel safe. She was warm (I).
- I waited to the weekly phone call impatiently. I was looking forward to sharing things with her; I wanted her advice and support (I).
- I didn't think that I'd expect your call so much (CF).
- I was talking with you in my head all week, waiting for our conversation (CF).

2. Providing new perspectives – specialists' perspective

- Clients say: "You give me tools" (FG).
- Clients say: "You helped me to see things differently" (FG).

2. New perspectives, insights and realizations – clients' perspective

- You broadened my point of view and opened new horizons (L).
- You helped me to see the same things differently (CF).
- …the ability to think differently from the way I always had (I).
- Thanks to you, I realized that so far I did not agree to live, because I was scared that by doing that I would be giving up on my son (CF).
- I feel that I've learnt I can get up in the morning with sadness, which is part of me, and still be able to smile, too (L).

3. Providing guidance – specialists' perspective

- The first thing that we have to do is help them to organize their chaos – in their thoughts and in the facts (FG).

- We provide guidance; sometimes we assume a parental role. We help them to make up an action plan, steps to guaranty implementation, and offer encouragement toward successful performance (FG).
- It is a collaborative work – first we define the goals, then we accompany them and we take decisions together. Things are done together. There is no arrogance of the caregiver who is all-knowing (FG).

3. Receiving guidance – clients' perspective

- She saw my exact situation and made me realize my predicament, how much I was in trouble and how much I needed help. She didn't sugar coat it but she believed in me and told me that if I got help I could get over it (I).
- You helped me to learn to overcome fear (L).
- You gave me tools and advice that, without you I do not think I would know (L).

4. Expression of emotions and management – specialists' perspective

- We help them moderate emotions, define emotions (FG).

4. Emotional expression – clients' perspective

- Perhaps you recall the moment when I cried terribly and told you something that was utterly secret. Nobody knows it. I only told you (L).
- I used to laugh with her and also cry to her (I).
- My wife is too sick and self-absorbed and cannot join with me in thinking about things I did or experiences I had (CF).
- I used to wait for your phone call because this was the only time I allowed myself to cry (L).

5. Providing understanding, empathy, and containment (non-judgmental) – specialists' perspective

- We provide understanding when they feel no one can understand them (FG).
- We provide understanding. Clients say: "with you I can say exactly what happens to me and you understand what I am talking about" (FG).

5. Experience understanding – clients' *perspective*

- There are tens of thousands of people like me. They are afraid to talk. They don't understand how a phone call can help. They don't realize how great it is that you always have someone to talk to. Someone always listens to you. There is someone that knows exactly what you are going through and how you are feeling (I).
- You are the only one who can understand what happened to me. You were obviously also in a terror attack (CF).
- I'm sure you are also a bereaved sister (CF).
- You gave me love and warmth, understanding and attention (L).
- It's so good that I can speak with you without being ashamed (CF).
- She focused all her attention on me. She gave me a place and told me I had to take care of myself (I).
- I am always thinking of others. In the conversations with you, I think of myself (CF).

6. The uniqueness of the medium – phone – specialists' perspective

- Since I am anonymous I can be anything for the client / Anonymity – it helps to overcome the inhibition of embarrassment, of shame (FG).
- The fact that they don't see you and you don't see them (FG).
- The client sees me in his own image (FG).
- The phone line is very accessible and the setting is very flexible. It's also free (FG).
- The uniqueness of the telephone is that people sit alone in a quiet secluded place; they speak but do not see the facial expressions or feedback – that focuses the person inward on his feelings and thoughts (FG).
- The phone allows a mental space which is not defined by almost anything, within it something flows that is not possible in a clinic treatment room (FG).

6. The uniqueness of the medium – phone – clients' perspective

- The phone allowed me to say things to you that I could not have said in person (L).
- This could not have come up in this way if I had seen you (talking about being disappointed about her son) (CF).
- To you, I can say everything because you do not see me (CF).
- I do not see you and your responses. This frees me and allows me to express myself with greater freedom. I can be more open and vulnerable (CF).

- The fact that she was on the phone made it easier to talk to her / I couldn't see her and she couldn't see me so I could tell her everything (I).
- I don't see you and this allows me to speak frankly and in an exposed manner (CF).
- I don't know you besides your voice, but I'm sure you are also a bereaved sister (CF).
- 'I didn't see him and his responses so it made me listen to myself' (I) , 'it is so comforting to know that there are people like me in NATAL' (L).

7. The uniqueness of the LIM – reaching out – clients' perspective

- You don't have to do much - you just have to pick up the phone. The funny thing is that you don't even have to pay for the phone - they call you! (I).
- I knew that you'd call me today. I've been waiting for your call (CF).
- I know you care about me because you keep on calling every week (CF).
- It's so encouraging to me when you call me (CF).
- It is a huge gift of endlessly giving with the aim of doing some good. They don't want anything in return - not money not anything. They even spend a lot of money on you because they call you. They called me for 7 years, every week, for half an hour - that's a lot of money! (I).

What are the observed changes in those problems during and after the phone interventions?

Three domains were identified by the participants, clients and specialists, as the observed changes in those problems during and after the phone interventions. The domains are: progress in clients' situation, mental health/clinical improvement, and better relationships and communication.

1. Progress in clients' situation – specialists' perspective

- Clients actually went through processes / clients made changes in their lives (FG).
- Clients regained their strengths and achieved daily functioning again (FG).
- Reduction of symptoms (FG).
-

1. Progress in clients' situation – clients' perspective

- My daughter continues to improve from session to session following conversation with you every Thursday at six PM (L).
- The lengthy period we have been conducting discussions, brings me to touch on something deeper each time, not all at once, and allows me to look inside more and more, and to express what I find (L).
- Every Tuesday I succeeded in seeing the world differently - a better world (I).
- She knew when to push me and when to give me some time and space (I).

2. Mental health/clinical improvement – specialists' perspective

- Clients who were finally willing to receive treatment in the clinical department (FG).
- Clients who stopped making further attempts to end their lives (FG).
- Some clients after struggling for years, come to terms with it and learn to live with the trauma. Some clients, following the intervention are able not just to survive but to enjoy life (FG).
- Clients say: "You know, now I can laugh…" (FG).

2. Mental health/clinical improvement – clients' perspective

- You showed me I can trust NATAL, so I think I am ready to see your therapist (CF).
- After I lost my son I didn't want to live anymore. You showed me that I can find a way to stay alive for my remaining family (L).
- You instilled in me the courage to dream (L).

3. Better relationships and communication - specialists' perspective

- We are a place where they experiment on us before saying things to others / during the intervention we see changes in communication and interpersonal relations of our clients (FG).
- The moment they are able to share their secret with us, it is also released to their family, and that breaks barriers so that intimacy and intra-family connections are strengthened (FG).
- Families of traumatized people usually don't understand all sorts of behaviors and symptoms they exhibit. Once we help the victims and they can communicate with their family, it creates understanding and compassion instead of anger / the intervention leads to movement within the family – a renewal of family communication, speaking about difficult things for the first time, daring to ask – this brings a sense of being understood (FG).

- Sometimes we strengthen one of the members of the family and this improves not only the well-being of the victim but also the well-being of the entire family / helping one family member, even in directly, has a cascade effect on the whole family (FG).
- The helpline assist in distributing the burden on the family and lowering their stress. It eases the pressure put on the family, so it helps the clients and family and allows for further processes (FG).

3. Better relationships and communication - clients' perspective

- Now, after I've spoken to you, I feel like I can tell my wife too (CF).
- She helped me cope better with my wife (I).
- I did not know what to do with my husband and his difficulties. Now I understand his struggles and try to help him cope better (L).

The therapeutic outcome (does the intervention improve clients' health and well-being?)

What do clients find helpful?

Four domains were identified by the clients as being helpful for them. The domains are: acceptance, perseverance, and care/concern.

1. Acceptance

- I feel comfortable talking with you. You don't judge me and you accept me even when you disagree with what I do (CF).
- I wish my wife would accept and understand me as much as X (specialist name) (I).
- You never reject me - even if I am screwed, hopeless, and even when I don't want to talk (CF).

2. Perseverance

- Every week, every week. She didn't stop calling. Sometimes I told her I don't feel like talking so she said she will call next week. She never forgot. She never gave up (I).
- You never gave up on me (L).
- My daughter is happy that you are there for her, and she knows you will always be there if she needs (L).
- I've been with NATAL for 7 years. 7 years that you didn't leave me - not even for a day (I).
- Someone is always there for you and that they never leave you. It gives such strength because you are never alone (I).
- You accompanied me through so many moments where without you I would not have succeeded in getting through them as I did, heroically and with strength (L).

3. Belief, hope

- The more I trusted her the more I learned to trust myself (I).
- You instilled in me the courage to dream and believe that I have much strength (L).
- She was involved in every aspect of my life. She helped me cope better with my wife (I).
- She believed in me and showed me that I am strong enough to stand on my feet (I).
- When everything seemed hopeless you helped me believe that things will get better (L).
- Now that I learned to better cope with the PTSD symptoms I hope I can find a job (CF).

4. Care and concern

- She got into my heart in a very smart way. She was gentle and caring, sensitive. Then the conversations became more intimate and profound (I).
- Even though we only talk on the telephone, I can see your smile and gentleness. I feel that you are helping me happily / I know you only say that because you care about me (CF).
- Thank you for caring for me and for taking care of me in the past two years (L).
- You never forget to call me, you remember me every week – it shows that you really care (CF).

What is the helpers' perception of what is helpful to the clients?

Similarly to clients' results, four domains were identified by the specialists, as being helpful for the clients. The domains are: acceptance/recognition, perseverance, belief/hope, and care/concern.

Additional two domains were indicated only by the helpline specialists as helpful for clients: nourishment and the larger impact of the intervention.

1. Acceptance and recognition

- They don't have to pretend or put on a show for us. They feel they can be their real selves and we accept them in any situation (FG).
- For them, the helpline is recognition - by an organization, by society / the helpline is a different place, where they can get recognition of their suffering (FG).
- We do not judge them / we are very accepting of them (FG).
- We are unconditionally available to them (FG).
- Clients say: "I feel how much you love me" (FG).

2. Perseverance

- Sometimes it is their experience that everyone around them is destroyed by their trauma and its effect. At the helpline, suddenly there is someone who is not. Not only are they not destroyed, but they continue to love them despite all. Not only are they not despairing, but they want to be with them despite (FG).
- They deposit a secret with us. We are a kind of safe (FG).
- We carry and hold their sack of burdens/sorrows. After the weekly call, they can get through the week easier without feeling weighed down because they left the sack with us (FG).
- We never give up on them – it amazes them, they test us and then they learn they can depend on us (FG).

3. Belief, hope

- Often our task is to hold on to a hope that the client no longer holds. He has given up on himself, on life, on the family. Actually, it is us who hold on to hope so that slowly, slowly they can begin to reconnect with it / the very act of calling them every week becomes one of their great sources of hope – they look forward to it (FG).
- Our belief in them is something that made it possible for them, actually, to start to believe in themselves and to make a change (FG).
- We cultivate their self-confidence: "If not for you I would never in my life have dared to do what I did" / we help them to identify their strengths and to enhance those strengths (FG).

4. Care and concern

- They feel that we care about them and that they are important to us - this is a very empowering feeling for a person / our calls every week provide a sense of connection and acknowledgment, they say: "you make me feel that I exist", "I belong, I am wanted… thanks for taking an interest in me" (FG).
- We support them; being their crutches and then helping them stand on their own two feet and walk. They feel that there is someone who holds them up, who won't let them fall (FG).
- We create a home for our clients, in the embracing sense, loving, accepting, protecting – a place they can always return to and will be always welcome (FG).

5. Nourishment

- We are like a gas tank for them. You fill them up so the car can go, and every week you fill them up again, like going to the gas station (FG).
- We are like an oasis in the desert. The client can rest, refresh, drink water, be nourished and then gather strength to move on, to continue the journey (FG).

6. A larger impact

- People who we help tell the people around them, and they pass it on. So it goes from mouth to ear that there is an organization that helps and that suffering people can be helped (FG).
- The well-being of the person has ramifications for the well-being of the whole community – our interventions have large impact (FG).
- The impact of a service like this is in raising awareness. Raising awareness establishes social legitimacy, and as a result of the two we have a certain prevention of deterioration and early intervention that can often help (FG).
- This is another channel for treatment that takes on and helps carry the burden of mental health services, which people use because it is more comfortable for them. So this service strengthens the mental health of the individual and the community, and also eases the burden on public resources (FG).
- The more the community provides services, especially voluntary services that don't cost; to members of the community it gives a strengthened sense of wellbeing in the community. It makes the whole society seem more welcoming and resilient (FG).
- A service like this strengthens national resiliency of a country. People feel that the state protects them and gives them a place to call when they are under pressure (FG).

- When people do good for others and when there is a larger group that represents the beautiful side of that population, there is something contagious in this, comforting. It demonstrates the benevolence and resiliency of this community. This service has great influence beyond the individual and in some way it percolates down to the community (FG).
- Additionally, the specialists brought up another element worth mentioning – non-threat:
- We are less threatening (than mental health professional treatment/formal institutions) (FG).
- The very fact that we do not define it as treatment allows more people to be helped, or open to it faster because it is not treatment, it is less threatening (FG).
- They have the control / they are taking control (FG).

PART VII

General Discussion

Chapter 12

General Discussion

The preceding chapter provided a report of the findings and the research results. In this chapter, these results of the research are discussed and related to existing knowledge. The first section discusses the quantitative results, next the qualitative results are discussed, and finally the discussion relates the results from the two research methods.

Discussion quantitative

'Work is love made visible'.

Kahlil Gibran

(Gibran, 2013)

The helpline impact

Which population is affected by the helpline / what are the callers'/clients' characteristics?

One of the research questions is aiming at exploring the impact of NATAL's helpline. This research question is investigated using both quantitative and qualitative methods. The impact can be determined by exploring the population which is affected by the helpline, and by ascertaining the characteristics of calls, callers and clients.

Incoming calls to NATAL's helpline

The data shows that from 1998 until the end of 2015 NATAL's helpline received 45,020 incoming calls. This data can reflect what was suggested by Ingram et al. (2008), who maintained that with many people in need of mental health and emotional support, crisis hotlines are in a position to provide services to a large number of people.

The number of calls received by the helpline is substantial, and it is reasonable to assume that many people were affected and helped by its operation. Yet, it may be useful to also explore the context of the helpline operation.

When Natal's helpline started providing services, in 1998, there was already a major helpline operating in Israel. This crisis hotline, ERAN, which was established in 1971, provides Emotional First Aid, and operates 12 call-centers around the country, with 1,000 volunteers. According to Gilat, Lobel and Gil (1998) and Gilat and Latzer (2007), who studied the helpline, it receives around 40,000 calls every year in a large variety of problems (e.g. mental illness, unemployment, divorce, loneliness, sexuality).

It is impossible to compare the number of calls received by NATAL and by ERAN because the data is collected in two different manners – ERAN counts every incoming call, whether it was answered or not, while NATAL only counts calls which were answered and dealt by the helpline specialists. Nevertheless, it is evident that ERAN is a much larger, more established helpline, which started to operate 28 years before the NATAL helpline, and also provides more diverse services to a larger population.

On the other hand, NATAL is a small organization, which was privately established, and doesn't receive any public/governmental funding. It operates only one call-center staffed by 40-50 helpline specialists, and provides services only to people who were affected by trauma and loss from terror and war.

In this context, with about 45,000 callers, it is reasonable to conclude that during the past 17 years, NATAL's helpline gained acknowledgment by the Israeli public, who consider it as a mental health resource for trauma and loss.

Evaluation of the helpline and the LIM is first and for most based on the characteristics of the callers. Helplines' callers have some universal characteristics which are described by Williams and Doubs (2012), who suggest that there are many relatively normal people whose sense of pride and integrity is threatened by coming to an agency. Such people may identify coming for help as being sick. A fear of a loss of self-esteem acts as a barrier to seeking help openly. Furthermore, they may perceive their need as quite temporary, in the sense that what they need at that moment is the presence of someone else so that they can think through their situation better. They do not want to become involved in a longer-term therapeutic relationship. A telephone counseling service is, perhaps, the only means by which such individuals can receive help (Lester & Rogers, 2012).

Researches indicate that most people who contact helpline are unwilling to seek professional mental health services (Gil, 2002; Mohr et al., 2005; Mozer et al., 2008; Burgess et al., 2008; Bee et al., 2010; Williams & Doubs, 2012). However, Coman et al. (2001) maintained that patients who oppose attending therapeutic sessions can benefit from telephone assistance until they are ready for face-to-face therapy.

The LIM provides an opportunity for callers to receive emotional support and mental health service on a long-term basis. This model offers people a chance to explore their experiences and struggles with an empathetic listener (who also has some training and knowledge of mental health), without having to face their inhibitions and stigmas – since the service isn't defined as 'therapy' and they aren't defined as 'patients'.

NATAL's callers are invited to become the helpline 'clients', and as shown by the results, 11% of them respond favorably and receive long-term assistance at the helpline.

In order to better understand this finding, it is possible compare it to a group which is defined by helplines as 'frequent callers'. Frequent callers are callers who call the helpline more than once, and usually make multiple calls, time and time again (Stein & Lambert, 1984). Scholars name and define them differently - They are commonly known as 'frequent' (Leuthe & O'Connor, 1980), 'chronic' (Imboden, 1980), 'multiple' or 'repeat' callers (Kinzel & Nanson, 2000).

Frequent callers can be compared to helpline clients, since both groups have multiple contacts with the helpline; they appear to need more assistance than a single call, and most helplines treat them as a specific group of callers (Kinzel & Nanson, 2000; Gilat & Latzer, 2007; Ingram et al., 2008).

Therefore, the finding of 11% of NATAL's callers becoming the helpline clients is compared to the number of frequent callers in other helpline. Gilat and Latzer (2007) report that 3.1% of ERAN's callers are frequent callers. Similarly, Spittal et al. (2015) found that 2.6% of callers to Lifeline (the largest crisis helpline in Australia) met the definition of frequent callers.

In light of these findings, it appears that NATAL's clients are a much larger group than frequent callers to other helplines. This may indicate that trauma and loss survivors have a greater need for assistance, it may also indicate that some helpline callers are in need of assistance greater than a single call, which usually can't be found in helplines – but since it is part of the LIM, it is offered to NATAL's callers, which accept it and become clients. This assumption can be tested only if and when helplines will offer their callers long-term phone interventions, yet the fact that most helplines deal with frequent callers can indicate to the existence of such a need.

This research also shows that after the helpline intervention, 28% of the helpline clients are willing to accept additional professional help, and are referred to and connected to therapy. This finding reflects the important role of the helpline as a bridge and mediator between absence of therapy and full psychotherapy.

Reinforcement to this finding can be found in a research made by Ledgerwood et al. (2013), who found that helplines represent a crucial point of intervention in the recovery process. They suggest that helplines represent an essential point of intervention with potential to offer brief interventions and to motivate callers to seek longer-term treatment.

It is encouraging to know that almost 1,400 people who reached out to the helpline, and were initially unwilling to go to therapy, were finally ready to do so. This indicates that the process at the helpline assisted callers to overcome some of their inhibitions, and combined with the psychoeducation they received regarding their situation and the de-stigmatization of therapy, both facilitated their way to therapy.

Causality - reason for calling

The data presented in Table 2 demonstrates the significant impact of wars among the Israeli population – the incident that led 40% of the callers to contact the helpline was one of the wars. Terror attacks are responsible for only 13% of the calls.

This important and noteworthy finding is supported by the professional literatures that acknowledge the change in the nature and impact of wars. Krippner and McIntyre (2003) and Boothby, Strang and Wessells (2006) suggest that in the past wars used to mainly affect soldiers, but today, wars also involve civilian populations.

The consequences of wars have received considerable attention in the recent literature. Studies on the countrywide impact of conflict show that affected countries and populations adjust economically relatively quickly and often return to their pre-conflict growth trajectories (Davis & Weinstein, 2002; Brakman, Garretsen & Schramm, 2004; Miguel & Roland, 2011). On the other hand, a growing body of research at the micro-level finds that conflict situations cause more mortality and disability than any major disease, destroy communities and families, and disrupt the development of the social and economic fabric of nations (Justino 2009, 2013; Kesternich, Siflinger, Smith, & Winter, 2014).

A considerable body of research of various wars, in different parts of the world, consistently found that war can have long-lasting effects on individual mental health through war trauma (Fox & Tang, 2000; Zakin, Solomon & Neria, 2003; Jaranson et al., 2004; Boothby, Strang, & Wessells, 2006; Palmieri, Canetti-Nisim, Galea, Johnson, & Hobfoll 2008; Cesur, Sabia & Tekin, 2013).

The deep and enduring pathogenic consequences of war related stress have repeatedly been documented, and showed that the long-term after-effects of war exist and impact survivors even 50 years after the war was over (Murthy & Lakshminarayana, 2006; Holdeman, 2009; Quy-Toan & Iyer, 2012; Gade & Wenger, 2011; Solomon, 2013; Bratti, Mendola & Miranda, 2015).

The state of Israel is going to be 70 years old next year. Since its inception it has known many wars which affected many combat soldiers, as well as large parts of the civilian population. Therefore, the

finding that 40% of the incoming calls to NATAL are the result of a war related trauma can reflect previous research findings – locally and globally.

Routine and emergency

Emergency

NATAL's helpline operates during routine times and also during emergencies/national crisis situations.

The data reveals that the calls to NATAL's helpline are divided almost equally between crisis calls (21,564 = 48%) and non-emergency calls (23,456 = 52%).

This finding is of great importance to the understanding of the helpline's operation and the pattern of the incoming calls:

Due to the unique situation, NATAL's helpline has to provide crisis interventions because there are many emergency situations which lead stressed people to call the helpline and seek help. As mentioned before, most of these callers will eventually be able to cope with the stressful situation and only need some assistance in the form of ventilation, psycho-education and mental health first aid (Kimhi & Shamai, 2004; Pfefferbaum, Reissman, Pfefferbaum, Klomp, & Gurwitch, 2007; Chandra et al., 2010; Ferrer & Conley, 2015). Therefore, many of the callers during crisis situations are provided with crisis intervention, which is usually a single-call intervention.

The non-emergency calls may also be single-call interventions, as callers seek information, advice and reassurance. Some of these calls may be the first exploratory step, to assess the helpline and evaluate its reliability. Then, some of these callers may contact the helpline again and will become clients. Furthermore, some of these callers will consent to engage in a relationship with the helpline immediately following the initial call.

Field experience indicates that there is a connection between specific traumatic events (e.g. war, terror attack, missile attack, natural disaster) and the number of incoming calls. Our experience also shows that media campaigns, which are inviting the public to contact the helpline for support, also have an effect on the number of incoming calls.

To verify the field experience, this study analyzed the monthly incoming calls and matched the numbers to the traumatic events and/or media campaigns occurring in each month.

As shown in Tables 3-5, there is a relationship between the incoming calls to specific events which may influence the number of calls.

It is reasonable to assume that trauma and loss survivors who carry their burden for a while will call the helpline when they feel the need to – which can be unrelated to national crisis situations. As Campos (2009) suggested, help seeking is often associated with an individual's current situation requiring some form of solution.

However, many people facing crisis situations, especially trauma and loss related to the security situation in Israel, are emotionally affected by those situations (Caplan, 1964; Kalafat et al., 2007; Dechesne, 2012) and therefore will call the helpline during the crisis itself or immediately after the crisis.

In conclusion, the literature support the results presented here, which show a rise in the number of incoming calls to the helpline whenever there is a crisis situation.

Another pattern that can be seen in those tables, especially in Tables 4 and 5, is that there is an increase of the incoming calls whenever there is a traumatic event, yet the numbers dramatically peak following major events, such as wars and military operations (which are also small-scale wars).

This pattern can be connected to results and conclusions of this study regarding the causality of the incoming calls. It is evident that wars not only trigger many people to call the helpline, but also prompt them to seek immediate help.

It may also demonstrate the crucial role of the helpline, as a supportive system, during crisis situation to the Israeli population.

Routine

The calculation of routine calls illustrates that more than half of the incoming calls (52%) are non-emergency calls. A further calculation, which is shown in Table 6, clarifies the pattern of the routine calls: the percentage of callers during routine time who become the helpline clients is 21%. This is a more accurate result than the 11% of clients out of the total number of calls, since it most of the people calling during a crisis will require only crisis intervention (Caplan, 1964; Kalafat et al., 2007; Neria et al., 2008) and therefore will not need further assistance nor will they become the helpline clients.

It is generally understood that people who are ready to accept help will usually contact a professional and not a helpline. Almost all of helplines' callers need assistance but are reluctant to admit that and refuse professional help, yet they will contact a helpline since it is not defined as "professional assistance" (Gil, 2002; Mohr et al., 2005; Mozer et al., 2008; Bee et al., 2010).

The result shown here, which indicates that NATAL's helpline is able to bring 21% of the callers at routine times, to become its clients, and consequently to receive more substantial assistance is a significant achievement.

Demographic data of callers

Callers - Gender

The results showed that the majority of callers to NATAL's helpline (58%) are female. This finding is strikingly similar to the data provided by one of Israel's largest helplines, ERAN, which reports that 58% of their callers are female (Gilat & Lazar, 2007). It is also in accordance with vast research results all over the world that revealed clear gender differences for hotline callers, indicating that the majority of helpline callers are female, regardless of age or type of helpline (Baron, Klein, & Thurman, 1980; Teare, Garrett, Coughlin, Shanahan, & Daly, 1995; Wunsch-Hitzig, Plapinger, Draper, & Del Campo, 2002; Franks & Medforth, 2005; Ingram et al., 2008).

This finding also reflects the well-known phenomenon and a common dilemma in the field of mental health services in that males are just as likely as females to be in need of services but less likely to seek help (Addis & Mahalik, 2003; Bertakis, Azari, Helms, Callahan, & Robbins, 2000; Clement et al., 2015; Galdas, Cheater & Marshall, 2005; Hatchett & Park, 2004; Husaini, Moore, & Cain, 1994; McKay, Rutherford, Cacciola, & Kabasakalian-McKay, 1996; Möller-Leimkühler, 2002; Oliver, Pearson, Coe & Gunnell, 2005; Padesky & Hammen, 1981; Thom, 1986; Wang, Hunt, Nazareth, Freemantle, & Petersen, 2013).

Callers - Age

Concerning age distribution, the results showed clear age differences. Most callers (40%) are between 50-75 years old.

A comparison of the age groups of callers between NATAL's helpline and ERAN helpline (Gilat & Lazar, 2007) reveals a strong difference. ERAN helpline reports that the largest age group of callers is 35-50 years old (47%), while the largest age group of callers to NATAL is 50+ years old (46%).

The NATAL data is also in contrast to callers' profile reported by global literature which shows that calls increased steadily until the ages of 30–39, where calls plateau until the ages of 40–49 and then decreased steadily throughout the rest of the lifespan (Dollard, Braunack-Mayer, Horton, & Vanlint, 2014; Hom, Stanley & Joiner, 2015; Ingram et al., 2008; King et al., 2014; Yang, 2016).

This finding is probably a reflection of the protracted consequences of one of Israel's most difficult wars - the Yom Kippur War. The generation that fought this war is 60-75 years old today. Also the generation that fought the (first) Lebanon War is 50-60 years old today. Therefore, the largest age group who calls the helpline represents people carrying the wounds from these wars.

This unusual data might also indicate that people approaching their retirement, which cope with major changes in their lives and routines, and who also carry the burden of trauma tend to seek help during this transition period.

It is worth noting that in recent years NATAL has made a significant effort to reach 2 age groups that were less likely to call the helpline:

i. Children and adolescents under 18 years old – until 2006 the NATAL's helpline didn't receive any calls from children and adolescents. In 2006, during the Second Lebanon War, we started receiving such calls, and after the war ended we opened a special helpline for children and adolescents. This age group naturally calls the helpline mostly in times of crises (wars and missile attacks) – and that explains the relatively low percentage of their calls (5%). NATAL is making an effort to advertise its services to this population, making sure it is accessible to children, yet we believe that the best interest of children is to rely on their natural support systems (their families and schools).

ii. Young adults – Israeli young adults usually follow a common path: they serve in the military until the age of 20-21. Usually between the ages of 21-30 they start arranging their adult lives – many of them travel the world for a year, they study and get higher education, and they start entering the labor market. They continue to serve in the military as part of the IDF's Reserve Force, and therefore are called upon whenever there is a significant security problem in Israel. Young adults are occupied with building a life for themselves and usually don't seek mental health services. Many of them carry emotional scars from their military service and it is important that they have a resource available in times of need. NATAL has initiated public awareness activities, especially in universities, in order to encourage young adults to seek help. Until recent years, only 5% of the callers were young adults. The rise today to 22% of the callers being young adults is very encouraging since it means that we can provide assistance to those people sooner rather than later, improving the prognosis.

Callers - Marital status

With regard to marital status the results showed that the majority (55%) of callers to NATAL's helpline are married or cohabit with their non-married partner. Our results stand in contrast to some other studies, which reported that the majority of callers to helplines were either single or divorced (Ingram et al., 2008). Similarly, Burgess et al. (2008) found that 36% of callers were never married, and 37% were divorced/separated. Only 24% were married or in a de facto relationship.

Another source which demonstrates that this is an extraordinary finding is data from one of Israel's largest helplines, ERAN, which reported that 65% of people who call the helpline were solitary people (Lazar & Erera, 1998; Gilat & Lazar, 2007).

It is reasonable to assume that the uniqueness of NATAL's field of operation - war and terror related trauma is correlated to this unusual finding of callers' marital status. It might indicate that people are less inclined to rely on their support system when coping with such trauma .

In light of the diminishing power and status of the family as a primary source of emotional support, it appears that helplines and other sources of social support are becoming more and more popular (Lazar & Erera, 1998).

Ingram et al. (2008) found that while studies of helpline callers have been focusing on small populations such as specific localities or types of problems, caller profiles are similar across the literature.

The data presented here show some differences between the callers to NATAL's helpline and callers to a major Israeli helpline (ERAN) and also to other helplines around the world. It is reasonable to assume that the focus of NATAL's helpline on trauma related to war and terror is responsible for these differences.

Demographic data of clients

Due to the fact that the operational model of NATAL's helpline is unique, and to the best of my knowledge there isn’t a helpline that provides longitudinal interventions similar to these, there is no possibility to compare the demographic data of our clients to data reported by other helplines in Israel or around the world (since other helplines don't have clients).

In order to better understand NATAL's clients' demographic data, it was compared to a group which is defined by helplines as 'frequent callers'. Since research show that there are differences between

the demographic data of helpline callers compared to helpline frequent callers, and also since multiple contacts with the helpline is a characteristic of the LIM and NATAL's clients – a comparison is made between these two populations in order to better understand the research results.

Additionally, in order to gain more insight, a comparison was made between the demographic data of NATAL's helpline callers and clients.

Clients - Gender

With regard to gender the results showed that the majority of the helpline clients (57%) are male.

These results point to a significant difference of a demographic characteristic between the helpline clients and the helpline callers – while 57% of the clients are male, only 42% of the callers are male. This difference was found to be statistically significant.

This extraordinary finding is anomalous in that: (a) it is dissimilar to the pattern reported by the literature that females tend to seek help more than male, and (b) it is reasonable to assume that when the majority of the callers to NATAL's helpline are female, so will be the majority of the clients – female.

It seems that in the case of NATAL's helpline, men use the LIM service more than women, contrary to the known phenomenon that men are less likely to use mental health services even though they are in need of these services as much as women (Addis & Mahalik, 2003; Bertakis et al., 2000; Burgess et al., 2008; Clement et al., 2015; Galdas et al., 2005; Hatchett & Park, 2004; Husaini et al., 1994; McKay et al., 1996; Möller-Leimkühler, 2002; Oliver et al., 2005; Padesky & Hammen, 1981; Thom, 1986; Wang et al., 2013).

One explanation of this finding can be that men in Israel are more willing to use mental health services via phone since it enables them to maintain their self-esteem. As was suggested by Lieblich (1983), strength is of tremendous importance to Israelis and their identity as individuals. The need for power is so central that any signs of weakness are regarded as threats to the identity and are, therefore, concealed from view. Since one is expected to demonstrate controlled, inhibited behavior, one ought to deny emotionality and sensitivity, block one's feelings of fear, grief and despair, and hide or scorn weakness of any sort (Shapira, 1998; Sasson-Levy, 2008).

Yet, there is evidence that this finding may point to a more universal phenomenon, larger than the Israeli context. Research exploring the demographic data of frequent callers showed similar results, that most frequent callers were male (Middleton, Gunn, Bassilios, & Pirkis, 2014; Spittal et al., 2015). These past findings and the results of this research reinforce men's need of mental health services and indicate that this need may be much stronger and overpowering than previously assumed, thus

leading men to search for a creative solution, which will enable emotional relief and support while maintaining self-esteem.

Therefore, this finding may provide an important understanding which will enable to break the barrier that prevents men from receiving the assistance they need.

Clients - Age

The results showed that the largest age group of clients is over 50 years old (40%), followed by adults between 35-50 years of age (30%).

The literature investigating the age of frequent callers to helplines show inconclusive findings: Burgess et al. (2008) found that frequent callers were older than other callers, while Middleton et al. (2014) found no differences between frequent callers and other callers with regard to age.

Another comparison showed that there are no significant differences in the age groups of the helpline callers vs. the helpline clients.

Clients - Marital status

The results showed that the majorities (61%) of the helpline clients are married or cohabit with their non-married partner.

This finding is contrasted to researches' results which showed that frequent callers were more likely to be unmarried compared to other callers (Burgess et al., 2008; Middleton et al., 2014; Spittal et al., 2015).

A comparison of the marital status between NATAL's clients to NATAL's callers showed a similar trend in that the majority of them are married. Yet, there is a difference in that while 55% of the callers are married, this characteristic is much stronger with clients, which 61% of them are married.

This finding indicates that most of the helpline clients have available support system, yet they prefer to use the helpline as a support system. I believe that the unique nature of the traumatic experience, which leaves people, detached and alienated from their families and communities (Herman, 1994; Attig, 2001), is responsible for this trend. Many times our clients tell us that the traumatic experience is so horrific they don't feel they can share it with other people, especially not with their loved ones. It is supported by the findings of Stein et al. (2004), who studied terror victims and found that almost half of them (43%) reported sometimes feeling unable to share their terrorism-related thoughts and feelings with others because it made others uncomfortable.

Since clients don't see the specialists while they talk with them over the phone makes it easier for them to share those experiences without being concerned with the impact on the listener.

This is an advantage of the helpline which may indicate to a possible powerful solution for people who have difficulties sharing their emotions or experiences. However, as mental health professionals it is vital that we acknowledge this finding and let it guide our intervention: it is important to be aware of the already existing support system so that we can encourage clients to recognize and utilize this available resource, thus strengthening the family and community and promoting recovery and resilience.

To conclude, the comparison between the demographic data of NATAL's clients to NATAL's callers and to other helplines' frequent callers showed varied results: there was a similar trend of certain characteristics, while other characteristics were dissimilar.

Number of callers per year

The results showed that the largest number of callers was in 2006, when 8,320 callers contacted the helpline. During that year there was a war in the northern border of Israel which affected large populations, and is probably the cause to the high number of callers.

The second and third large numbers of callers are in the years of 2014 (5,025 callers) and 2012 (4,381 callers). During these two years there were two major military conflicts in the southern border of Israel (mini-wars) which also affected large populations, and are probably the cause to the high number of callers.

Additionally, Table 10 clearly demonstrates that the average yearly number of callers (2,688) is significantly smaller than the yearly number during major security crises (8,320 / 5,025 / 4,381).

To conclude, the results showed that major security crises affect the number of callers to the helpline, and as a result of such situations there is an increase in the number of callers who contact the helpline.

Results of previous studies in Israel reinforce this conclusion, and estimate this trend at an increase of about 40% calls (Gilat, Lobel & Gil, 1998). However, a more profound exploration of the

literature reveals much higher rise and also the cause to this rise: Raviv (2014) and Milgram (1993) described the change for the Israeli population, which happened in 1991, during the Gulf War. Until then, wars were characterized by a defined front line, whereas for civilians the threat was relatively defined and limited. Yet, in the Gulf War, almost the entire population of Israel was under the threat of a direct attack. This new and threatening situation was also reflected at hotlines: Gilat, Lobel and Gil (1998) found that a remarkable change was recorded in both the quantity and quality of calls received in hotlines in Israel during the Gulf War. The relative frequencies of problem categories presented by callers during the Gulf War revealed a significant increase in “environmental pressures,” a category that reflected the stressful situation of the war, as opposed to intra- or interpersonal problems typical of peacetime calls.

Similarly, wars and military operations of the major security crises in recent years in Israel were characterized by posing a threat to the whole civilian population in Israel, thus affecting many. For example, during one of the last conflicts, in 2014, 4,594 rockets were fired into Israel. They spread beyond the border areas up to an 80km distance, and 70% of the population was exposed (Levanon & Gidron, 2015; Bodas, Ben-Gershon, Rubinstein, Bergman-Levy, & Peleg, 2015).

The need and use of hotlines during such periods is much higher. Bodas et al. (2015) found that in 2012, during “Pillar of Defense” operation, telephone-based mental assistance (i.e. “hotlines”) rose. Also, data of the incoming calls to crisis helplines in Israel in 2014 (Operation Protective Edge) showed a rise by over 300 percent from their regular traffic (Levanon & Gidron, 2015).

This result can reinforce the phenomenon reflected at NATAL's helpline – comparing the average yearly number of callers, 2,688 to the yearly number of callers during the last war in 2006, 8,320 shows a rise of 309.5%. A comparison to NATAL's yearly number of callers during other major security crises show rise of 160%-190%.

Levanon and Gidron (2015) found that these hotlines serve as an index as to the range and magnitude of anxiety. The findings of this research can also attest to the unique role of helpline as a source of psychological first-aid in a community crisis situation. As Bodas et al. (2015) suggest, people seem to prefer having their tensions relieved in the comfort and assurance of their own homes instead of having to travel to a nearby, designated center.

Number of callers vs. clients per year

It was hypothesized that the yearly number of clients will be related to the yearly number of the callers to the helpline. The results showed that there is indeed such link, and the more callers contacted the helpline each year, the larger the number of clients became.

Unfortunately, this finding cannot be compared to other findings because of the uniqueness of the model. There isn't any available data relevant to frequent callers which can serve as a comparison.

NATAL's helpline interventions

Characteristics of the longitudinal interventions

The results showed wide-ranging characteristics of the helpline clients and the comprehensive responses provided to them by the helpline specialists. The longitudinal interventions include a tentative intervention plan with preliminary goals, focuses and types of interventions (e.g., containment, skill development etc.) which can lead to achieving those goals. Some people who have encountered duress due to a traumatic event need information, guidance, and new ways of coping. Yet, others need a trauma-focused in-depth intervention in the form of CBT, imaginal exposure, narrative reconstruction or psychodynamic treatment.

The diverse manifestation of clients' struggles and needs are also reflected in the variety of psychological approaches and treatment techniques. Mott, Stanley, Street, Grady, & Teng (2014) suggest that the treatments available for PTSD span a variety of psychological categories. These interventions are used both separately and in combination with one another, and appear to be backbones of treatment cited in treatment guidelines. Although no clearly defined "preferred" approach is available for managing patients with PTSD, each of these guidelines supports the use of trauma-focused psychological interventions (i.e., those that treat PTSD by directly addressing thoughts, feelings, or memories of the traumatic event).

The results of this study show that the LIM integrate many of the available treatment techniques.

Also, as was suggested by Littleton et al. (2007), the two main groups of coping strategies within the trauma and loss treatments are *Emotion-focused strategies* and *problem-focused coping strategies. Emotion-focused strategies* focus on managing the emotional distress and include disengaging from emotions related to the stressor, seeking emotional support, and venting emotions**.** The results showed that these strategies are used during the intervention: Stress-related Emotional ventilation (41.60%) and Community connectedness (38.40%).

Problem-focused coping strategies directly address the problem causing distress and include seeking information about the stressor, making a plan of action, and concentrating on the next step to manage or resolve the stressor. The results showed that these strategies are used during the intervention: Psychosocial education (90.10%) and Self-help tools (25.60%).

The variability of interventions that were provided, suggests that the helpline interventions were able to provide diverse and wide-spread answers for different needs and different populations.

Therapeutic main approach

The results showed that the two main approaches which characterize the helpline interventions include dynamic elements (23.3%) and cognitive elements (20.9%). Narrative elements were applied less often (9.3%).

It is important to note that helpline specialists are trained to include different therapeutic approaches in the intervention, on the basis of what best suits the client. During the training all the elements are given the same attention and knowledge, and therefore there is no reason for the specialists to favor one type of elements over the other. It is reasonable to assume that this data echoes the practice-based knowledge accumulated in the helpline which suggests that dynamic and cognitive elements are most beneficial to the helpline clients.

These results can be supported by Ogburn (2015) who found that psychodynamic modes of treatment have long been in use for traumas and have been historically applied to PTSD, and also by McLean and Foa (2011) who found that CBT is considered as one of the popular treatment approaches in clinical practice guidelines for PTSD by the American Psychiatric Association.

The outcomes of the helpline interventions

Symptoms and functioning level

The helpline interventions showed significant results of therapeutic impact: there was a general decline in functioning problems, and an improvement in the severity of symptoms. This study suggests that interventions done by the telephone specialists, according to the LIM, improved both the functional status, as well as the symptomatology status of the clients.

There is extensive literature exploring the unique impact of PTSD symptoms on physical and mental health functioning. There is some evidence for a negative (indirect) relationship between PTSD symptom severity and daily functioning. That is, PTSD symptoms seemed to negatively impact physical health symptoms, which in turn were associated with poorer daily functioning (Foa et al., 2008; Wilson, Friedman & Lindy, 2012; Levi, Bar-Haim, Kreiss, & Fruchter, 2015). The impact of PTSD symptoms on social functioning is described by Wilson et al. (2012) who found that PTSD can result in altered appraisals of oneself and environment that can undermine one's capacity to function. Also, Traumatized patients withdraw from social connections as a result of the active PTSD avoidance symptoms, and consequently develop socially avoidant habits which persist and result in social dysfunctions (Cella, 1995; Levi et al., 2015).

Accordingly, there is a consensus among scholars regarding the treatment of PTSD. One primary outcome in PTSD treatment is symptom reduction. Other outcomes are improved quality of life and improved functioning (Foa et al., 2008; Mott et al., 2014; Schumm, Dickstein, Walter, Owens, & Chard, 2015; Seligman, 1995). Additionally, Cella (1995) found that Symptom relief is highly valued by patients and usually is associated with improvement in general functioning and well-being.

However, although studies suggest an association between PTSD and poorer functioning in general, the impact of PTSD symptoms on functioning remains unclear. Some scholars (Yeager & Roberts, 2003; Sharpless & Barber, 2011; Peri & Gofman, 2014; Foa et al., 2008) suggest that symptoms reduction have an effect on functioning level (e.g. improvement in sleep may improve daytime activity). Others, such as Asnaani, Reddy and Shea (2014) and Bryant et al. (2016) maintain that it appears that there are functional scars from having PTSD, and that PTSD may leave residual functional effects on people despite remission of their PTSD symptoms (Bryant et al., 2016).

It can be concluded that although phone interventions in general are not defined as therapy and usually don't attempt to be therapy, the results of phone interventions done according to the LIM show therapeutic affect and achieve conventional treatment goals.

In contrast to the results of this research, which show significant improvement in clients' general functioning, as well as symptom relief, many studies show no improvement of frequent callers' condition (Middleton et al., 2014). Helplines' research show that frequent callers contact crisis helplines continuously with recurring problems, without appearing to make discernable positive changes over time (Farberow et al., 1966; Wilkins, 1969; Greer, 1976; Ingram et al., 2008; Middleton et al., 2014).

This difference in the results suggests that it is not the mere existence of the phone intervention that is helpful for clients, but rather the type of the phone intervention and what it provides. It reinforces the conclusion that the LIM is affective in improving clients' difficulties.

In conclusion, the quantitative results clearly show that indeed longitudinal telephone interventions can significantly improve both quality of life as well as functional status of clients suffering from trauma and loss.

This section discussed the quantitative results. The following section will discuss the qualitative results.

Discussion qualitative

'We hear only those questions for which we are in a position to find answers'.

Friedrich Nietzsche

(Nietzsche, 1996)

To follow is a discussion of the qualitative results. Below the findings are related to results obtained in previous, relevant research.

The helpline impact

What are the callers'/clients' characteristics / which population is affected by the helpline?

One of the queries this research is aiming to explore is the impact of NATAL's helpline, which can be determined by discovering the characteristics of callers and clients and also the problems/struggles they present. This will show which population is affected by the helpline.

This data was collected from the helpline specialists during the focus groups sessions. The results show that the helpline specialists who described the callers and clients, focused on their psychological, emotional and social characteristics– and not on their demographic characteristics. This finding may help characterize the callers and clients of the helpline from a wider perspective, as well as complement and enrich the description which was based on the quantitative data.

Reinforcement to this approach can be found in the field of marketing, where the attempts to 'humanize' quantitative data begun. Emanuel Demby (1994, 2011) struggled with traditional demographic variables, such as gender, age, income and education – realizing that although they can be used to describe the characteristics of a group of people, they cannot identify the complete characteristics of such group. Demby used the term 'psychographics' as a spinoff from the more familiar and more conventional 'demographics' (Reynolds & Darden, 2011). While demographic data is the dry data, the hard facts like age and gender; the psychographic data forms the personality of the person, their likes, interests, and habits. Psychographics is the study of personality, values, opinions, attitudes, interests, and lifestyles (Demby, 2011; Dolnicar & Randle, 2007; Reynolds & Darden, 2011).

Interestingly, the results show that the helpline specialists referred to psychographic data of the callers/clients and not to their demographic data. The reason for this finding may be found in the literature - scholars found that when first encountering others, people are relatively uncertain about what they are like, how they will behave, and how to behave toward them (Berger, 1987; Sunnafrank, 1986). Therefore, people seek to reduce this uncertainty by gathering information about others (Berger & Kellermann, 1994; Sunnafrank & Ramirez, 2004). The information gathered can relate to demographics and/or to psychographics. However, the research regarding stereotypes (Bathje & Pryor, 2011; Brown & Bradley, 2002; Crowe, 2013; Crowe & Averett, 2015; Smith & Cashwell, 2010, 2011) can suggest it is reasonable to expect the specialists to focus on the demographics and not on the psychographics: stereotypes are categories of objects or people. Stereotypes can help make sense of the world, because they help to simplify and systematize information. Thus, information is more easily identified, recalled, predicted, and reacted to.

Consequently, stereotyping the callers/clients is natural and logical (in terms of psychological and behavioral efficiency), and could be expected from the helpline specialists. The fact that the opposite

was found, can be explained by the results of a research done with nurses. Zolnierek (2014) asked nurses what promotes their understanding of patients. He found that understanding reflects 'knowing the patient' and promotes personalized and patient-centered responses. Understanding is facilitated by communication and involves connection, engagement, and attunement with the patient. Therefore, knowing the patient was characterized by “in-depth knowledge of the patient’s patterns of responses and knowing the patient as a person”.

It is reasonable to assume that the longitudinal connection with the helpline clients led to a process where “knowing about the patient” was replaced by personal knowing of the patient, and therefore to an awareness of the psychographic characteristics instead of the demographic, more stereotypical characteristics.

The psychographic characteristics of callers/clients, as were described by the specialists referred to their emotional state and social state. Callers were described as people facing a critical moment or a crossroad, which leads them to experience distress, internal chaos and a sense of a dead end.

This phenomenon is supported by Kessler et al. (1981) who found that when the problem is most acute, subjective barriers break down and enable the utilization of mental health services.

Additionally to this emotional state, they also struggle with social difficulties, feeling misunderstood, and invisible to their surroundings, seeking compassion from their family and friends.

This emotional and social state could be an obstacle for them to seek help, yet the specialists emphasized that the unique character of the service assist in overcoming this barrier – the accessibility, flexibility and the affordability of this service allow clients to approach it despite their weakened state.

This is also reflected by the literature which suggested that the ease of access, convenience, cost, and the perceived control are all factors which lead many people to choose helplines as their preferred mental health service (Campos, 2009).

Which problems/struggles clients present?

The helpline specialists categorized clients' problems/struggles to two main groups: (a) PTSD symptoms (sleep/nightmares, aggressiveness, agitation, flashbacks), and (b) Grief symptoms (sleep, detachment, preoccupation with loss, inability to experience joy).

This result is compatible to the well-documented consequences of trauma and loss, which showed that an exposure to a traumatic event is frequently followed by the development of PTSD (Neria et al., 2008; Dechesne, 2012). Also, experiencing the death of a loved one may lead to varied reactions to loss and to a grieving process (Yalom & Lieberman, 1991; Neimeyer et al., 2010).

However, the specialists also emphasized another major problem which is presented by the helpline clients and that is loneliness.

This finding is also well-documented by the professional literature, which found that traumatic events tear apart familial, friendly, romantic and community ties, leaving the victims feeling alone (Herman, 1994). Also, people said that their loss left them feeling lonely (Frantz et al., 2001; Rubin, 1981, 1999; Stroebe & Schut, 1999).

The therapeutic process (what are the characteristics and the effect of the intervention?)

The participants in this research identified seven topic areas which characterize the intervention and the therapeutic process. The topic areas are: safe place, new perspectives/insights/ realizations, guidance, emotional expression, providing understanding/empathy/containment (non-judgmental), the uniqueness of the medium – phone, and the reaching-out component which is unique to the LIM.

Safe place

Both helpline specialists and helpline clients referred to the importance of a safe place to the therapeutic process.

The helpline specialists expressed a belief that their role is to create a safe place for the helpline callers (e.g. 'I have to create the safe place pretty quickly so that the client will stay with me').

This finding indicates that the helpline specialists internalized and confirmed with the training they were provided, since one of the principles of the LIM is the necessity to create a safe place.

This view can be found in mental health literature, where there is a consensus among therapists that the first requirement of psychological work is to create a safe place (Ayalon & Lahad, 2001). A safe place was defined by Winnicott (1965) who said that the therapy situation should become a "holding environment" which is a safe place for the client. Like infants, troubled individuals need to feel safe before they can explore (Rogers 1961). Therefore, as Young et al. (2003) said, therapists seek to create a situation that provides safety, stability and acceptance.

In the safe place the patient is affirmed and the expression of needs, desires, and feelings is encouraged (Ayalon & Lahad, 2001). This is compatible to the view of Rogers (1961) that trust can be defined as a state of being; in which people believe that their needs can be met without injury by others or their environment.

Similarly, the helpline specialists emphasized the need to focus on listening to the callers (e.g. 'active listening ear') and their awareness to the fact that sometimes the helpline is the only place which allow and encourage expression (e.g. 'I was just about the only person he had in the world').

The perception of a safe place has even greater importance for trauma survivors, as suggested by Sewell and Williams (2001) who found that mental health professionals must deal with the psychological and social impacts of terror because of the understanding that central human expectations that bodies remain intact, the world is safe, life is fair, and so on are clearly invalidated by situations of war, terrorism and similar such events. Similarly, according to Lahad (2001) the person-centered approach is especially suited to trauma survivors because of its overriding emphasis on the establishment of a safe, trusting relationship.

To conclude, it was found by past research that the creation of a safe place is a crucial component for therapy, especially when trauma and loss are involved. The helpline specialists in this study confirmed their commitment to this view.

This study also allowed for a comparison between the perspectives of clients (i.e. helpline callers/clients) and the service providers (i.e. helpline specialist). The qualitative results show that the helpline clients were aware of the attempt to make them feel comfortable and safe (e.g. 'she said: "you are not alone"), and also found it reassuring (e.g. 'I agreed to give my phone number because she made me feel safe').

In sum, the results show that clients who struggle with disclosure and exposure (e.g. 'it wasn't easy to open up and share my story and my feelings') later become more at ease in the relationship and appreciate the ability to work-through their troubles (e.g. 'I waited to the weekly phone call impatiently. I was looking forward to sharing things with her').

New perspectives, insights and realizations

The helpline specialists found that their clients perceived the intervention they provided as offering new perspectives (e.g. 'clients say: "you helped me to see things differently"').

The results show that the helpline specialists didn’t refer to the value of providing new perspectives and didn’t address this topic as an important part of their role (dissimilarly to the creation of a safe

place). The helpline specialists emphasized this aspect as a feedback they receive from their clients, and therefore see it as a characteristic of the intervention.

This finding can indicate that the helpline specialists' perception of their role is similar to Mattila's (2001) description, which suggests that a client should feel free to talk about himself/herself and his/her attitudes and thoughts. Therefore, the helpline specialists work to create an atmosphere which will encourage this kind of sharing. In other words, the results show that the helpline specialists consider the attainment of new perspective as a natural and welcome result of creating a safe place for the client, rather than an independent goal.

However, scholars claim that the acquisition of a new understanding or insight is called “mechanisms of change” (Gabbard, 2000), and it is recognized as an important state of change through various theoretical approaches in psychotherapy (Moro, Avdibegović, & Moro, 2012). Additionally, Winston and Muran (1996), suggest that many psychotherapies work by raising the patient’s awareness and developing new insights (Carey, Carey, Mullan, Spratt, & Spratt, 2009).

Since the helpline specialists are not mental health professionals, it is possible that they are not fully aware of the exact role of gaining new perspectives. However, it is also possible, that differently from mental health professionals they associate that with 'giving advice' and therefore aspire to achieve that as an outcome and not as a goal. Support for this explanation can be found in the words of Goldsmith and Fitch (1997), who defined advice as providing another point of view in making a decision, and assistance in laying out options. Additionally, they suggest that giving advice can signal that the advice giver has greater expertise in the subject and therefore provides expert opinion on how to solve a problem. Such attitude is considered inappropriate according to the LIM, and therefore it is natural that the helpline specialists try to avoid being perceived by their clients as experts or advice-givers.

The helpline clients, on the other hand, seem to value the ability to broaden their point of view (e.g. 'see the same things differently..... to think differently from the way I always had'). Moreover, they appreciate the opportunity to gain new insights and realizations during the phone intervention (e.g. 'Thanks to you, I realized that so far I did not agree to live, because I was scared that by doing that I would be giving up on my son').

This finding indicates that the helpline specialists do encourage their clients to enter what Vermeire, Hearnshaw, Van Royen and Denekens (2001) call 'psychic laboratory of understanding', so they can come to new discoveries about themselves. This enables clients to find new perspectives on health beliefs in general and of their illness in particular (Vermeire et al., 2001).

To conclude, the results show that both the helpline specialists and clients consider gaining new perspectives and insights as a characteristic of the intervention. Also, while clients and scholars find this element to be significant, the helpline specialists tend to avoid working directly towards achieving it and prefer to support it as an indirect outcome.

Guidance

The results indicate that the helpline specialists believe that their role is to help organize the therapeutic/rehabilitative process of the clients – 'we help them to make up an action plan, steps to guaranty implementation, and offer encouragement toward successful performance', 'first we define together the goals, then we accompany them and we take decisions together'.

This finding is supported by the literature. Guidance is defined as advice or information aimed at resolving a problem or difficulty, especially as given by someone in authority (Barker, 2003). Another definition is supervised care or assistance, especially therapeutic help in the treatment of minor emotional disturbances (Roeckelein, 1998; Colman, 2015)

Al-Krenawi and Graham (2000) found that clients expect social workers to explain the nature of their problems and to supply solutions, rather than trying to discover solutions for themselves. Thus, they suggest that helping should be direct and clear, with concrete targets. It should provide guidance, advice, direction, explanations, and instructions.

The guiding role of the helpline specialists, in accordance to the findings of Al-Krenawi and Graham (2000) is also reflected in the clients' views - 'you gave me tools and advice that, without you I do not think I would know', 'she saw my exact situation and made me realize my predicament, how much I was in trouble and how much I needed help. She didn't sugar coat it but she believed in me and told me that if I got help I could get over it'.

Additionally, several studies provide evidence that therapeutic guidance has an advantageous effect on treatment outcome (Baumeister, Reichler, Munzinger, & Lin 2014; Johansson & Andersson, 2012; Palmqvist, Carlbring, & Andersson, 2007; Spek et al., 2007; Titov, Andrews, Choi, Schwencke, & Mahoney, 2008). Baumeister et al. (2014), for instance, provided evidence that internet-based interventions including therapeutic guidance yielded better results than interventions without guidance (Rheker, Andersson, & Weise, 2015).

Therefore, it seems that similar to the literature, the helpline clients expect some guidance from the specialists, who provide it during the intervention.

However, the helpline specialists presented different views regarding the power balance related to guidance. Some of them see the responsibility and power as unequal – 'we provide guidance; sometimes we assume a parental role'. Others emphasized the shared cooperation as a characteristic of the process – 'it is a collaborative work –things are done together. There is no arrogance of the caregiver who is all knowing'.

This finding may indicate to the attitude expected according to the LIM, which emphasize the empowerment of clients. It may also indicate that the specialists want to discern themselves from mental health professionals, who are perceived by clients (and sometimes also by the specialists) as authoritative, all-knowing people.

The literature presents conflicting results and guidelines regarding the incorporation of guidance in therapy (Friedman, 2015; VandenBos, 2007). Especially in the field of trauma, the role of guidance is perceived differently, according to the psychological approach (Reyes et al., 2008).

To conclude, according to Patterson (2000), counselors should not "attempt the arrogant and self-defeating task of guiding clients". Yet, Andersson (2014) suggests that the amount of guidance should differ according to the condition of the patient. The results show that the helpline specialists offer guidance to clients, who expect and accept it.

Emotional expression

The helpline specialists described this aspect of their work with their clients as "help them define emotions and moderate emotions".

This is consistent with the professional literature of the psychodynamic approach which directs the therapist to focus on affect and expression of emotion (Shedler, 2010). Also, according to the PE approach, emotional expression is encouraged, because the overall aim is to help trauma survivors emotionally process their traumatic experiences in order to diminish PTSD and other trauma related symptoms (Foa et al., 2008).

The importance of emotional expression for trauma survivors is emphasized by the Iraq War clinician guide (Litz & Orsillo, 2004), which recommend that veterans will be encouraged to use emotional expression as ventilation, to better regulate their anger responses.

Many mental health protocols endorse emotional expression, especially for trauma survivors. Additionally, according to Roter, Frankel, Hall, and Sluyter (2006), affect and emotion are important components of relationships, and therefore emotional expression may have positive affect on the relationship of the therapist and client, and also on other relationships of the client.

The results also show that the helpline clients value the opportunity to express their emotions (e.g. 'I used to laugh with her and also cry to her'). The need to share and ventilate is probably one of the main drives leading people to call a helpline.

Actually, scholars found that emotional expression is a basic expectation of the caller. A study which examined the help-seeking characteristics of callers to the ten Israeli hotline centers during the Intifada (the Palestinian uprising in the Israeli administered territories), found that a major expectation of the callers was to receive emotional support at the helplines. Callers felt a need to share their concerns and thoughts with someone understanding so as to receive legitimization for their anxieties and other feelings (Gilat & Latzer, 2007).

Similarly, Gates (2015) found that 89% of the callers to parental helpline were satisfied with the helpline and found it helpful because it fostered the expression of feelings.

Boddy, Smith and Simon (2005) suggest that the capacity of a helpline to enable ventilation of callers' emotions and concerns is worthwhile.

The results indicated that many clients referred to their ability to cry during the phone conversation (e.g. 'I used to wait for your phone call because this was the only time I allowed myself to cry') – therefore, it seems that what they value is more than the opportunity to express their emotions – it is the opportunity to express emotions they are unable to express elsewhere.

Providing understanding, empathy, and containment (non-judgmental)

The results show that the helpline specialists see themselves as providing understanding to their clients. More than that, they receive feedback from their clients – e.g. 'clients say: "with you I can say exactly what happens to me and you understand what I am talking about".

Bodie, St. Cyr, Pence, Rold and Honeycutt (2012) and Weger, Castle Bell, Minei and Robinson (2014) found that competent listeners are attentive and understanding. Additionally, Timulak and McElvaney (2013) and Lilliengren and Werbart (2005) found that one of the main components which aid clients' progress in therapy is the acceptance and understanding of the therapist.

According to Binder, Holgersen and Nielsen (2010), clients report that being understood and having their experiences accepted as valid allowed them to internalize the therapist's voice and to explore.

The helpline specialists emphasized the aspect of providing an unusual experience to the clients – 'we provide understanding when they feel no one can understand them'. That can indicate to the

loneliness and frustration of trauma survivors, which can be eased by the presence of the helpline specialist who becomes a constant source of understanding and acceptance. Scholars found that being deeply understood and accepted helps clients engage in self-reflection nondefensively and increase their self-awareness – promoting the therapeutic process (Levitt, Pomerville & Surace, 2016; Dollarhide, Shavers, Baker, Dagg, & Taylor, 2012).

The results show that helpline clients feel understood ('you gave me…understanding and attention') by the helpline specialist. Moreover, this understanding and empathy is perceived as so great and unusual, that they interpret it as having first-hand knowledge - 'you are the only one who can understand what happened to me. You were obviously also in a terror attack'.

According to Hojat (2007) and Brockhouse, Msetfi, Cohen and Joseph (2011), empathy is the art of understanding, reflected in perspective taking, standing in another's shoes, tolerance, openness, uncritical judgment, and unconditional acceptance.

Empathy entails capturing the nuances and implications of what people say, and reflecting this back to them for their consideration (Elliott, Bohart, Watson, & Greenberg, 2011). Therefore, the primary task of the empathic therapist is to understand experiences rather than words (Irving & Dickson, 2004). This is a key to the therapeutic relationship. In fact, empathy is one of the driving forces in effective working with the suffering in general, establishing and maintaining the therapeutic alliance (Figley, 1995; Figley, 2002). It has been found that the empathy perceived by patients has the potential to directly affect the success of the treatment and the healing process (Kim, Kaplowitz & Johnston, 2004; Nambisan, 2011).

To conclude, empathy and understanding were found by scholars as important and crucial elements for therapy and as having an effect on the outcomes of the therapeutic process. The results show that the helpline specialists believe they provide empathy and understanding to their clients, and clients feel they receive empathy and understanding from the specialist. Both parties assign importance to the presence of empathy and understanding in the relationship.

Another goal of the therapist is to contain the patient's feelings during difficult periods in treatment (Tolan & Cameron, 2016). Bion (1962) developed the concepts of 'contained container' and identified the potential of therapeutic relationships to act as containers for unmanageable feelings, thereby enabling people to address the situation they are facing (Ruch, 2007).

The ability to face difficult feelings as a result of the specialist's presence and containment is demonstrated by a client's feedback – 'it's so good that I can speak with you without being ashamed'.

To conclude, the profound effect of understanding, empathy and containment is described by one of the helpline clients, who said: 'there are tens of thousands of people like me. They are afraid to talk.

They don't understand how a phone call can help. They don't realize how great it is that you always have someone to talk to. Someone always listens to you. There is someone that knows exactly what you are going through and how you are feeling'. This client actually refers to his own experience, being afraid and feeling misunderstood before calling the helpline, and then feeling contained and understood at the helpline.

The uniqueness of the medium – phone

The results show that helpline specialists see three main advantages to using the phone as the medium of communication with their clients. Firstly, they believe that clients communicating over the phone, without seeing the specialist, are having a liberating experience which helps clients to get rid of difficult feelings such as shame and guilt (e.g. 'it helps to overcome the inhibition of embarrassment, of shame'). Secondly, they found that the phone enables clients to focus inward, since they don't see the specialist, and therefore aren't distracted (e.g. 'they don't see the facial expressions or feedback – that focuses the client inward on his feelings and thoughts'). Thirdly, they think that not seeing the specialist through the phone brings clients to imagine the specialist, which makes them create the ideal specialist for them (e.g. 'the client sees me in his own image', 'I can be anything for the client').

These three characteristics of the effect of the phone were also found in clients' perspectives. Firstly, clients expressed their feeling of liberation as a result of not seeing the specialists or being seen by them (e.g. 'not seeing you frees me and allows me to express myself with greater freedom. I can be more open and vulnerable', 'this allows me to speak frankly and in an exposed manner'). Secondly, clients described the ability to focus on themselves as a result of the absence of external stimulus (e.g. 'I didn't see him and his responses so it made me listen to myself'). Thirdly, the results show that clients see themselves and their image in the specialists, although they don't know anything about them (e.g. 'I don't know you besides your voice, but I'm sure you are also a bereaved sister', 'it is so comforting to know that there are people like me in NATAL').

These findings are consistent with the literature. The liberation and protection which callers experience as a result of anonymity are described by Skårderud (2003), who suggests that anonymity during the phone conversation reduces the inhibition and allow callers to speak more freely. Additionally, Meissner (2002) elaborates that anonymity offers some protection for clients to express their thoughts and opinions with little repercussion. Moreover, Firth et al. (2005) found that

the phone offers intimate anonymity to callers - a sense of emotional closeness as a result of interacting with an anonymous and visually inaccessible other. To conclude, callers can feel protected and therefore their willingness to make contact and open up is greater (Karon, 1991).

Secondly, the anonymity also allows clients to explore feelings and attitudes with little fear of judgment (Firth et al., 2005). Therefore, it facilitates greater self-revelation and openness (Williams & Doubs, 2012).

Thirdly, the benefit of not seeing the therapist was recognized by traditional psychoanalysis, which placed the analyst out of sight behind the client, thus restricted the visual cues for both (Lester & Rogers, 2012). It is one of the principles of psychoanalytic therapy originally set by Freud (1912). Using the therapeutic sofa, Freud successfully prevented eye contact between therapist and patient, as well as the effects of body language and facial expressions on both patient and therapist, letting vocal communication transfer all the different shades of intonation. Psychoanalysts therefore sit behind their patients, so that the former may become formless voices (Gay, 1993).

The benefit resulting from the lack of eye contact when using the telephone is described by Lester and Rogers (2012), who found that the anonymity of the helper/therapist at the helpline allows callers to imagine, consciously or unconsciously, how they would like the therapist to be. This phenomenon can be related to projection: projection refers to seeing one's own traits in other people (Spillius & O'Shaughnessy, 2013; Tansey & Burke, 2013). West (2014) describes projection as the denying of one's unconscious qualities (positive or negative) and attributing them to others. Similarly, this phenomenon can be related to the concept of false consensus, which is defined as a tendency to assume that others are similar to oneself (Abelson, Frey, & Gregg, 2014; Krueger & Clement, 1994). Therefore, the finding that clients see themselves in the helpline specialist can be explained as projection and false consensus.

Additionally, Melanie Klein saw the projection of good parts of the self as leading potentially to over-idealization of the object (Segal, 2012). Therefore, clients who project their positive qualities onto the helpline specialist may be idealizing the specialist. This is consistent with Lester and Rogers (2012), who found that the telephone contact, much more than the face-to-face interaction, permits the patient to make of the therapist what he will. This has the crucial implication that he can make of the therapist what he needs. The anonymity of the therapist facilitates the development of transference, which can be used to facilitate positive growth of the patient.

To conclude, the anonymity and absence of eye-contact which characterize the phone intervention were found to be beneficial by the helpline specialists and clients. This finding is consistent with professional literature in the field of psychology, as well as literature in the field of tele-health.

<u>The uniqueness of the LIM – reaching out</u>

The LIM combines several unique characteristics, which are untraditional to therapy and to phone interventions. One such characteristic is reaching-out; the helpline specialist calls his/her clients once a week, reaching-out to the client.

The results show that the helpline clients value and appreciate the reaching-out of the helpline specialist (e.g. 'it's so encouraging to me when you call me'). This finding is consistent with the goals of reaching-out that are described by the literature. According to Bond et al. (1991), from its earliest beginnings, reaching-out has sought to provide something different: the sort of service which people would want and value. The results also indicate that the aspect which clients value is the concern that is manifested by the reaching-out (e.g. 'I know you care about me because you keep on calling every week'). This is also described by the literature which suggests that reaching-out usually offers active community treatment and intensive support (Cupitt, 2009; Van Citters & Bartels, 2004). The literature emphasizes the activeness aspect of reaching-out, and relates that to the characteristics of the target population; the clients commonly needing reaching-out are adults with severe and persistent mental health difficulties associated with a high level of disability. They frequently dislike mental health services, are alienated from wider society and struggle on alone (Wright et al., 2003; Coombs & Dillon, 2002). Likewise, according to Cupitt (2009), it is about offering hope to people who have often become alienated and disenfranchised.

The results show that helpline clients appreciate being freed from the burden/stress of seeking help, and being able to take a more passive position (e.g. 'you don't have to do much - you just have to pick up the phone', 'I knew that you'd call me today. I've been waiting for your call').

This finding was also present in the helpline specialists' perspective, who described the callers, similar to what was found by the literature - 'people who come to us don't go for treatment because of their inhibitions', 'clients can be less active and can be weaker or show less strength in their ability of taking the initiative'. According to Bond et al. (1991) and Wright et al. (2003), outreach programs have been successful in engaging reluctant clients who have shunned conventional mental health programs. Reaching-out has been found to engage clients in the service.

Reaching-out is commonly described as actively offering treatment to people who need much support (Van Citters & Bartels, 2004; Nxumalo, Goudge, & Thomas, 2013; McGivney, 2000). The results may offer an opportunity to explore reaching-out from the perspective of the service providers. The helpline specialists emphasized the experience of responsibility rather of activism. The helpline specialists felt that it is their role and responsibility to maintain the relationship with the client - 'this is different from a clinic where it is the responsibility of the patient to get there', 'at the helpline the

responsibility is ours to maintain the connection, the continuity. The client has a responsibility only to carry out his process'.

The results show that the specialists believe that at the helpline, as opposed to treatment, they are responsible for holding the connection with the client, and share responsibility for the process and the outcome. This finding is of importance to the organization, since it may have implications on burn-out and compassion fatigue, and therefore needs to be further explored by the management.

Another interesting and even surprising finding was discovered during the interviews with the helpline clients. Clients seem to be cognizant of the financial side of the service they receive (e.g. 'the funny thing is that you don't even have to pay for the phone - they call you!', they even spend a lot of money on you because they call you. They called me for 7 years, every week, for half an hour - that's a lot of money!').

This finding is surprising because it emerged only during the interviews and didn't appear in any other resource of the study. Data from the helpline clients was collected from three sources; case files, 'thank you'/closure letters and interview. None of the case files (438), nor the letters (12) didn't contain any such reference.

Although letters are much shorter than interviews and it is reasonable to assume they contain less data, this cannot be said about case files, which are extensive and contain rich data. It is expected that this data is also found in case files. A possible explanation can be that the data residing in letters and case files are directed from the client to the specialist, and therefore mainly refers to their relationship. The interviews were conducted in the office of NATAL, and that may influence the clients to also refer to the organization and not just to the specialist.

Whatever the reason may be, this finding revealed information which can provide an answer to an internal organizational debate. A few years ago, the organization's management wanted to change the type of phone service offered, so that instead of a toll-free number, callers will be charged for a small amount of money (regardless of the length of the conversation). This proposed change wasn't expected to affect the callers, since the cost for a caller was estimated in a few Israeli Shekels – less than one US Dollar. Yet, the helpline management, the helpline specialists and some of the professionals in the organization's steering committee opposed this idea.

The rationale behind this opposition was that it was believed by some to be very important that the organization provides a service which is completely free of charge. Considering the characteristics of the callers, it is known that many of them find it difficult to trust people and services, and thus providing a cost-free service can attest to the good intentions of the organization and the service (although most of the services the organization offers are subsidized, the helpline is the only cost-free service). It was finally decided to keep the helpline with a toll-free number.

Studies found that the cost of mental health services has been reported as one of the major barriers to service use by multiple groups (Abrams, Dornig, & Curran, 2009; Kopelman et al., 2008; Leis, Mendelson, Perry, & Tandon, 2011; O'Mahen & Flynn, 2008). The effect of the cost of the mental health service was also demonstrated in a study which investigated callers' experiences of contacting a national suicide prevention helpline. Many respondents thought that these services can be better if the cost of calling will be reduced (Coveney, Pollock, Armstrong, & Moore, 2012). Similarly, Reese et al. (2006) found that 79% of clients appreciated telephone counseling because it was free of charge (part of their benefit package).

Consistent with the literature, this finding indicates that clients appear to value and be thankful for the helpline service being free of charge - 'it is a huge gift of endlessly giving with the aim of doing some good. They don't want anything in return - not money not anything'. It seems that providing a cost-free service is indeed perceived by clients as a reflection and validation of benevolence and altruism – by the organization, the helpline and the specialist.

What are the observed changes in those problems during and after the phone interventions?

The participants pointed out three main changes which occurred as a result of the intervention: progress in clients' situation, clinical improvement of clients' mental health, and better relationships and communication of clients.

Progress

The results show that all the participants in this study observed some changes and progress – whether their own change (as clients) or change/progress affecting a close family member who is treated at the helpline (e.g. 'I succeeded in seeing the world differently', 'my daughter continues to improve from session to session following conversation with you').

The helpline specialists witnessed reduction of symptoms in their clients and also observed that clients regained their strengths and achieved daily functioning again, following the phone intervention. They all believed that: 'clients actually went through processes / clients made changes in their lives'.

Data obtained from all the qualitative sources indicates that there is a consensus regarding the existence of changes and progress following the helpline intervention, manifested by improved symptoms distress and better functioning.

This is conforming to the literature suggesting that a primary outcome in PTSD treatment is symptom reduction. Other outcomes are improved quality of life and improved functioning (Foa et al., 2008; Mott et al., 2014; Schumm et al., 2015).

Mental health/clinical improvement

The results show that some clients, who were contemplating suicide before/during the phone intervention, could find a reason to live following the intervention. The helpline specialists referred to having 'clients who stopped making further attempts to end their lives'.

Similarly, clients' case files and 'thank you' letters showed the same trend (e.g. 'after I lost my son I didn't want to live anymore. You showed me that I can find a way to stay alive for my remaining family').

Additionally, some clients who previously refused any professional help, became compliant to this possibility (e.g. 'clients who were finally willing to receive treatment in the clinical department').

The results indicate that the relationship with the helpline specialist may serve as a bridge to therapy (e.g. 'you showed me I can trust NATAL, so I think I am ready to see your therapist').

Considering the fact that many people who need help refuse therapy due to stigma and other reasons (Ingram et al., 2008; Kazdin & Blase, 2011), it is encouraging to see that helpline intervention may promote help-seeking.

Another mental health improvement which was found is enhanced well-being of clients. The helpline specialists observed that: 'some clients after struggling for years, come to terms with it and learn to live with the trauma. Some clients, following the intervention are able not just to survive but to enjoy life'.

Similarly, clients expressed such improvement saying: "you know, now I can laugh…", 'you instilled in me the courage to dream'.

Such existential distress and the need for meaning-making and regaining well-being can be found in the literature: Seery et al. (2010) suggest that adverse life events typically predict subsequent negative effects on mental health and well-being. Additionally, studies found that most people who are coping with loss or trauma do not find meaning, even many years after the event (Davis, 2001;

Neimeyer et al., 2010). Consequently, Calhoun and Tedeschi (2001) propose that the goal of trauma treatment is to move the client in the direction of greater well-being and reduced distress. Similarly, Silver et al. (2005) suggest that treatment should address patients' decreased subjective well-being and encourage meaning-making.

The improvement experienced by the helpline clients can be supported by previous findings, which indicate that people who seek practical assistance from others may be best able to find meaning and well-being (Updegraff et al., 2008).

Better relationships and communication

The helpline specialists agreed that: 'during the intervention there are evident changes in communication and interpersonal relations of clients'. They perceived it to be an outcome of the helpline intervention, and described several reasons and processes leading to this outcome.

It was found by previous studies that trauma and loss survivors find it difficult to share the experience and their emotions with their family and friend (Bonanno & Kaltman, 1999; Cyrulnik, 2009; Herman, 1994; Grand, 2000; Silverman, 1986)

The helpline enables trauma/loss survivors to overcome this barrier – first at the helpline and later with their relatives. The helpline specialists described this process: 'we are a place where they experiment on us before saying things to others', 'the moment they are able to share their secret with us, it is also released to their family, and that breaks barriers so that intimacy and intra-family connections are strengthened'.

This process of breaking the silence with the helpline specialist as a first step of the revealing process was also described by the clients – 'now, after I’ve spoken to you, I feel like I can tell my wife too'.

The helpline specialists defined this outcome as improving the communication within the family, which brings about better understanding and better relationship – 'families of traumatized people usually don't understand all sorts of behaviors and symptoms they exhibit. Once we help the victims and they can communicate with their family, it creates understanding and compassion instead of anger', 'the intervention leads to movement within the family – a renewal of family communication, speaking about difficult things for the first time, daring to ask – this brings a sense of being understood'.

'Being understood' is another important outcome, since better understanding leads to the improvement of the relationship and better support. This was described by the helpline specialists: 'sometimes we strengthen one of the members of the family and this improves not only the well-

being of the victim but also the well-being of the entire family', 'helping one family member, even indirectly, has a cascade effect on the whole family'.

Similarly, clients expressed this process as impacting several family members – 'I did not know what to do with my husband and his difficulties. Thanks to you, now I understand his struggles and try to help him cope better', 'she helped me cope better with my wife'.

To conclude, the intervention is aimed at promoting the communication between the trauma/loss survivors and their family members, which leads to better understanding and improves the relationships within the family. Helpline specialists and clients thought this goal is achieved during the intervention.

The therapeutic outcome (does the intervention improve clients' health and well-being?)

What do clients find helpful? What is the helpers' perception of what is helpful to the clients?

Four domains were identified by the clients and specialists, as being helpful for clients. The domains are: acceptance, perseverance, belief/hope, and care/concern.

Acceptance

The helpline clients expressed feeling accepted by the helpline specialist and found it to be beneficial – 'I feel comfortable talking with you. You don't judge me and you accept me even when you disagree with what I do', 'you never reject me - even if I am screwed, hopeless, and even when I don't want to talk'.

This finding matches the findings of previous studies which found that when the specialist shows empathy, understanding and acceptance, then the clients feel safe (Rogers, 1957; Havens, 1996). Additionally, it was found that the experience of safety helps to develop an invaluable sense of true connection in the therapeutic relationship (Levitt et al., 2016; Dollarhide et al., 2012; Lilliengren & Werbart, 2005). The connection between acceptance and the therapeutic bond can be demonstrated by the words of one of the clients, who said: 'I wish my wife would accept and understand me as much as (specialist name).

Similarly, there was a very strong consensus among all the helpline specialists regarding the importance of conveying acceptance of the clients – 'we do not judge them / we are very accepting

of them', 'they don't have to pretend or put on a show for us. They feel they can be their real selves and we accept them in any situation'.

In summation, Kalafat (2012) suggested that the helper should convey acceptance of the caller and of the problem. The results indicate that the helpline specialists purposefully express their acceptance, and that the helpline clients feel accepted by the specialists.

Perseverance

The helpline clients expressed appreciation to the continued and constant presence of the specialist in their life – 'I've been with NATAL for 7 years. Seven years that you didn't leave me - not even for a day'. This tenacity is perceived by them as fortitude of the relationship and support provided by the specialist – 'my daughter is happy that you are there for her, and she knows you will always be there if she needs', 'someone is always there for you and that they never leave you. It gives such strength because you are never alone'.

The results indicate that the helpline clients value the perseverance of the specialists – a result which is consistent with the literature demonstrating to the importance of therapists' perseverance.

Perseverance is defined as a continued effort to do or achieve something despite difficulties, failure, or opposition (Colman, 2015). A certain amount of perseverance is necessary in order to meet challenges (Dale, 1997).

In their study, Medeiros and Prochaska (1988) found that the greater the degree to which therapists relied on optimistic perseverance, the better they saw themselves as coping with stressful clients (Quinn, 2002). In another small, intensive study of 5 borderline patients successfully treated by experienced analytically oriented therapists, Waldinger and Gunderson (1989) noted that the therapists' perseverance over time was an important factor. A common thread was that all the therapists had an unusually strong commitment to persist at the difficult work of therapy until a satisfactory outcome was achieved (Glen & Gabbard, 2000). In fact, Natale and Stern (2014) emphasized the importance of providing clients with a secure therapeutic setting in which the therapist shows support, acceptance, and perseverance. Similarly, Twible and Henley (2000) found that therapist attribute of perseverance helps patients during times of stress, and over time will help them to overcome apparently insurmountable obstacles.

The above mentioned findings of previous literature is also reflected in the findings of the helpline specialists' viewpoint – 'sometimes it is their experience that everyone around them is destroyed by their trauma and its effect. At the helpline, suddenly there is someone who is not. Not only are they

not destroyed, but they continue to love them despite all. Not only are they not despairing, but they want to be with them despite'.

The specialists' description – 'we carry and hold their sack of burdens/sorrows. After the weekly call, they can get through the week easier without feeling weighed down because they left the sack with us' – is suited to the above reference of Twible and Henley (2000).

As described before, the LIM offers reaching-out to clients. The consistent reaching-out in itself is perceived by the clients as perseverance of the helpline specialists. They feel that despite their resistance, the specialist is committed to them and to helping them – 'you never gave up on me', 'every week, every week. She didn't stop calling. Sometimes I told her I don't feel like talking so she said she will call next week. She never forgot. She never gave up'.

This quotation is well-matched to a specialist's quotation – 'we never give up on them – it amazes them, they test us and then they learn they can depend on us'.

These quotations were taken from different interviews. Unfortunately, the written form cannot convey the tone of voice of the speakers, nor the emotional manner it was expressed. That attests to the significance of this finding and the worth it holds in the eyes of the participants. It may also reveal the factor leading to the impact and the success of the intervention.

Belief, hope

The results show that helpline clients feel that the specialist believes in them and in their strengths, and that makes them to start believing in themselves – 'she believed in me and showed me that I am strong enough to stand on my feet', 'the more I trusted her the more I learned to trust myself', 'you instilled in me the courage to dream and believe that I have much strength'.

Similarly, the helpline specialists described their role as expressing the belief and hope for the clients and thus regenerating that within the clients – 'our belief in them is something that made it possible for them, actually, to start to believe in themselves and to make a change'.

This aspect of regenerating the hope and belief within the clients was not only emphasized but also explained by the specialists – 'often our task is to hold on to a hope that the client no longer holds. He has given up on himself, on life, on the family. Actually, it is us who hold on to hope so that slowly, slowly they can begin to reconnect with it'.

These results support the existing knowledge, which defines hope as the knowledge and feeling that there is a way out of difficulty, that things can work out, that the person can somehow handle and manage a challenging situation (Larsen, Stege, & Flesaker, 2013).

Over the years, studies have shown that having hope plays an integral role in an individual's recovery (Kulka et al., 1990; Levi, 2013; McCranie, 2010). Further, in a large scale survey, Park, Peterson, and Seligman (2004) revealed that of all positive psychology variables examined, hope was most consistently and robustly associated with life satisfaction (Larsen & Stege, 2010).

Additionally, hope may protect against psychological distress for people who experience traumatic events (Glass et al., 2009). In fact, a hopeful disposition has been associated with superior coping and less psychological distress under conditions of mild to moderate stress (Irving, Telfer, & Blake, 1997; Snyder, Irving & Anderson, 1991).

Another aspect of hope was described by the helpline specialists, as connected to one of the characteristics of the LIM - 'the very act of calling them every week becomes one of their great sources of hope – they look forward to it'.

Likewise, scholars found that hope may strengthen and empower the client to believe that a better future is possible (Frank & Frank, 1991; Hanna, 2002; Larsen & Stege, 2010). This is reflected in clients' feedbacks – 'when everything seemed hopeless you helped me believe that things will get better', 'now that I learned to better cope with the PTSD symptoms I hope I can find a job'.

To conclude, according to Kalafat (2012), helpers should convey a sense of hope for the caller's efforts to at least start to resolve his or her concerns. The results show that the helpline specialists believe in clients' strength and express that belief and a hope for a better future. Similarly, clients think that the helpline specialists convey their hope that clients' distress will improve, and a belief in their strengths – a belief which is transferred to the clients and assists in renewing their own hope and belief.

Care and concern

The results show that the helpline clients experience care and concern conveyed by the specialist - 'she got into my heart in a very smart way. She was gentle and caring, sensitive. Then the conversations became more intimate and profound', 'even though we only talk on the telephone, I can see your smile and gentleness. I feel that you are helping me happily'.

The results show that it is the attitude of the specialists which makes the clients feel their care and concern, yet there is no specific indication to what exactly is responsible for this experience.

The helpline specialists also described their concern for the clients – 'they feel that we care about them and that they are important to us - this is a very empowering feeling for a person'.

Concern is defined as marked interest or regard usually arising through a personal tie or relationship (Colman, 2015). Other definitions are: to have a specific connection with or responsibility for, and to be interested or involved with.

When helpers convey concern, they demonstrate their interest and involvement with the recipient of their assistance, which in turn might be interpreted by them as an indication to connection.

The distinction between concern and empathy isn't very clear. Researchers have long been interested in the relationship between feeling what you believe others feel—often described as empathy, and caring about the welfare of others—often described as compassion or concern (Batson, Lishner, & Stocks, 2015).

Daniel Batson (Batson, 2013) suggested the term 'empathic concern', referring to the ability to feel compassion and concern for others who have negative experiences. Empathic concern is felt when one adopts the perspective of another person in need (Batson, 2014), and the emphasis is that it relates to feeling for the other and not feeling as the other feels.

To sum, Jordan, Amir and Bloom (2016) propose that concern is in fact how much one cares about other people.

Therefore, one answer to the quandary mentioned above may be described by Kalafat (2012) who found that helpers convey their concern by encouraging the caller to talk, and care by demonstrating their attentiveness to what happens to the caller. Some of the findings can relate to this description: 'I know you only say that because you care about me', 'thank you for caring for me and for taking care of me in the past two years'.

Similarly, the helpline specialists described their concern by using a powerful metaphor 'we create a home for our clients, in the embracing sense, loving, accepting, protecting – a place they can always return to and will be always welcome'.

The literature suggests that there are clear benefits to integrating caring into mental health practice (Benner & Wrubel, 1989; Freedberg, 1993; Halstead, Wagner, Vivero, & Ferkol, 2002; Noddings, 1992; Peloquin, 1993; Roach, 1987; Swanson, 1993; Watson, 1988). Also, Kuehl, Newfield and Joanning (1990) found that clients who viewed their therapists as caring and personable were more likely to be satisfied with their therapeutic experience.

Likewise, mental health caregivers themselves feel satisfaction when they have the opportunity to demonstrate caring behaviors (Schofield & Bloch, 1998). Additionally, caregivers described the

benefits of caring as a sense of closeness to the care recipient, and enhanced self-esteem (Ashworth & Baker, 2000; Savage & Bailey, 2004).

It is important to mention another finding which may indicate that one of the characteristics of the LIM, the continued and constant reaching-out of the specialist, is in fact responsible for the experience of care – 'you never forget to call me, you remember me every week – it shows that you really care'.

This aspect was also described by the helpline specialists – 'our calls every week provide a sense of connection and acknowledgment, they say: "you make me feel that I exist", "I belong, I am wanted… thanks for taking an interest in me"'.

Additional two domains were indicated only by the helpline specialists as helpful for clients: nourishment and the larger impact of the intervention.

Nourishment

The helpline specialists found that one of the supportive elements they provide to their clients, which was indicated as being helpful, is nourishment. The specialists used metaphors when they described the nourishment they provide to clients – 'we are like a gas tank for them. You fill them up so the car can go, and every week you fill them up again, like going to the gas station', 'we are like an oasis in the desert. The client can rest, refresh, drink water, be nourished and then gather strength to move on, to continue the journey'.

These descriptions portray an image of supplying some undefined emotional needs without pinpointing exactly the needs or the way they are fulfilled. Perhaps the difficulty to explain this element led the specialists to produce a physical and tangible metaphor to such an elusive component. This can also be the reason for the absence of this topic from clients' descriptions – it may be too complicated for them to identify, define and realize those vague emotional needs and their fulfillment.

It is also evident that the specialists' impression is that these emotional needs are constantly getting empty and therefore have to be continually fulfilled on a regular basis. The weekly intervention of the

helpline enables the specialists to continuously fill this void, thus supporting and facilitating the journey and process the clients are engaged in.

The literature describing mental health treatments has almost no references to the subject of nourishment. The minor mentions seem to be relatively vague, in terms of description, importance and direction.

Human encounters can nourish a person and provide experiences of joy, happiness and well-being (Greenwald, 1976). Relating the element of nourishment to therapy, Kurtz (1990) suggests that if a therapist provides the right nourishment that the patient truly needs, the patient will accept only what is needed and when replete with nourishment will move from dependency to exploration of the world at large.

According to Varvin and Rosenbaum (2011) traumatized patients may find themselves in a situation of need and confusion, an existential crisis, where internal basic trust is not working. In this cases safety and emotional nourishment has to be supplied from the therapist. Likewise, one major role of Body-Centered Psychotherapy is helping the client feel nourished by internal resources (Kaplan, 2006).

The process of building resources through personal nourishment and fostering emotional, supportive connections has been evidenced to promote resiliency and thus diminish the consequences of stress (Perez et al., 2015; Zambrano, Chur-Hansen & Crawford, 2013).

In an analysis of the literature, pertaining to patient spiritual needs, it was found that hope has the power to nourish patients and replenish their spirit (Galek, Flannelly, Vane, & Galek, 2005).

To conclude, the results show that the helpline specialists see themselves as providing on-going nourishment to their clients, which supports their progress during the intervention. Yet, clients didn't acknowledge nourishment as a helpful characteristic of the helpline intervention. This finding might be related to the elusiveness of this concept and its role, as perceived in the actual treatment process and as reflected so limitedly in the literature.

The larger impact

The helpline specialists conveyed an observation that the helpline has a larger impact on the community and society – larger than the clients and their families. The specialists also shared their opinions regarding the topic areas which are affected and the reasons behind this effect.

The first area the specialists referred to is that the helpline produce legitimacy to seeking help and to receiving mental health services – 'the impact of a service like this is in raising awareness. Raising awareness establishes social legitimacy, and as a result of the two we have a certain prevention of deterioration and early intervention that can often help', 'people who we help tell the people around them, and they pass it on. So it goes from mouth to ear that there is an organization that helps and that suffering people can be helped'.

This observation of the specialists relates to a known phenomenon at the helpline – many callers tell the specialist that they heard about the helpline from someone who received help from the helpline in the past and recommended the service to them. In fact, according to the data, 6% of the callers (who agreed to disclose how they heard about the helpline) contacted the helpline through such referrals.

Additionally, this finding is in accordance with NATAL's Vision Statement – 'To advance awareness and knowledge about National Psycho-trauma and terror and war related PTSD in Israeli society' (NATAL, n.d 1). This vision is promoted by NATAL's Public Education Department, which works to position NATAL in the public's awareness as a leading organization that helps and offers a broad system of quality services to people who are emotionally injured as the result of terrorism and war. One of the public awareness activities is a Public Education Campaign that deals with everything related to increasing society's awareness of national psycho-trauma and its influence on individuals and Israeli society (NATAL, n.d 2).

This aspect of the organization's vision, and the specialists observations found in this study, are consistent with the literature dealing with nonprofit organizations. According to Ryan (2002), nonprofits see their mission as more than the delivery of services. They also act as advocates and vigorous agents of social change, challenging society to respond to human problems in new ways. Similarly, Benjamin and Campbell (2015) suggest that organizations which adopt practice frames that accentuate increasing clients' access to services attribute some or all of their clients' problems and needs to environmental or structural deficits rather than exclusively to personal factors. Because their practice frames shift blame, at least in part, from the individual to the environment, these organizations are more likely to adopt strategies aimed at changing the system (Bass, Aarons, Guinane, Carter, & Rees, 2007; Dees, 1998). That is, they are more likely to engage in social benefit advocacy (Garrow & Hasenfeld, 2014; Shier & Handy, 2015).

NATAL's vision and philosophy is that manmade disasters, such as terror and war, have profound effect on innocent people's lives, and therefore it is a civic duty to care and treat the survivors. Therefore, the organization sees it as its duty, not only to provide services and treatment to these people, but also to raise awareness to their situation and advocate on behalf of them.

To evaluate its success in awareness-raising, NATAL has conducted in the last decade, several nationally representative health surveys. A health survey is a systematic collection of factual data

pertaining to health and disease in a human population within a given geographic area. Health surveys provide information about the sources, magnitude, and impact of health problems, and the roles of programs and providers in addressing these problems (Aday & Cornelius, 2006; Rea & Parker, 2014). Nationally representative health surveys provide evaluation data and impact evaluation indicators for population and health activities. It provides survey data for health care providers who can act to improve public health (Salazar, Crosby, & DiClemente, 2015).

The health survey which NATAL conducts is used to look at people's knowledge and attitudes regarding trauma, PTSD and treatment services. Also, it provides information regarding NATAL's brand awareness. Brand awareness refers to the extent to which customers are able to *recognize* a brand (McDougle, 2014; Rossiter, 2014).

Brand awareness helps NATAL evaluate its accessibility to its potential clients, and the results of the health survey are used to help plan NATAL's services.

The health surveys showed that in 2004, when the first survey was conducted (6 years after NATAL was established), the brand awareness was 30%. These health surveys were conducted approximately every two years, and showed a gradual and consistent growth in NATAL's brand awareness. The last health survey, conducted in 2015, showed that NATAL's brand awareness more than doubled itself, and is now 70%. This is an impressive outcome, which indicates that NATAL's efforts of raising-awareness are indeed successful.

The data documented at the helpline shows that approximately 38% of the callers (who agreed to disclose how they heard about the helpline) contacted the helpline following an awareness-raising campaign. This is the largest source of callers to the helpline.

Another point of view expressed by the helpline specialists with regard to the larger impact of the helpline relates to social cohesiveness and resiliency - 'a service like this strengthens national resiliency of a country. People feel that the state protects them and gives them a place to call when they are under pressure', 'the more the community provides services, especially voluntary services which don't cost to members of the community, it gives a strengthened sense of wellbeing in the community. It makes the whole society seem more welcoming and resilient'.

The connection between nonprofit organizations (e.g. NATAL) and social cohesiveness can be found in the literature. Social cohesion is the set of characteristics that keep a group able to function as a unit (Onyx, 2014). According to Larsen (2013), social cohesion is defined as the willingness of members of society to cooperate with each other in order to survive and prosper.

Harrison, Montgomery and Bliss (2016) suggest that nonprofit organizations are mission-driven organizations supported by civic volunteer forces and therefore affect and are effected by social cohesion. In fact, according to Borzaga and Galera (2014), civil society consists of two elements:

individual civic engagement and civil society organizations. Together these elements aim to maintain and to enhance coexistence and cohesion within society.

Additionally, organizations of civil society (nonprofits) relieve the state and municipalities in the fields of social services, inpatient healthcare etc. creating conditions and opportunities for individual development and for civic engagement. Civic engagement is defined as “a cooperative activity that is voluntary, not geared for a personal material gain and oriented towards common welfare (Smith et al., 2016).

To conclude, nonprofits provide an opportunity for citizens to become engaged in the community, thus contribute to a healthy civil society (Hasenfeld & Garrow, 2012; Shier, Handy, & McDougle, 2014).

The results show that the specialists emphasized the role of NATAL as a nonprofit organization providing a cost-free service as the helpline, in supporting public services - 'this is another channel for treatment that takes on and helps carry the burden of mental health services, which people use because it is more comfortable for them. So this service strengthens the mental health of the individual and the community, and also eases the burden on public resources'. Since nonprofits typically provide services to individuals who are ineligible under government rules or they improve services for those who are eligible (Davies, 2014), it can be concluded that the specialists identify the social role of the helpline, in addition to the personal/individual input.

Secondly, the results show that similar to scholars who found that the goal of civil society is to maintain and to promote social cohesion which enables citizens to trust each other (Anheier, 2013; Edwards, 2013; Tester, 2014), also the helpline specialists appreciate this impact of the helpline – 'when people do good for others and when there is a larger group that represents the beautiful side of that population, there is something contagious in this, comforting. It demonstrates the benevolence and resiliency of this community. This service has great influence beyond the individual and in some way it percolates down to the community'.

To conclude, because many researchers operate exclusively within either a quantitative or qualitative frame of reference, few exploit the possibilities for integration of both methods in the same research. Yet this more eclectic approach may have significant advantages. Therefore, consistent with Neimeyer and Hogan's (2001) suggestion, this research took a stance of methodological pluralism, respecting both numbers and narratives and the distinctive forms of understanding that each can promote.

Originating from a philosophy which holds that human knowledge is socially and personally constructed, with no single view laying claim to universal validity or absolute truth, the goal of this research is less to generate incontestable “facts” than to discover and explore the unique and

common perspectives of the individuals and the service that were studied. Therefore, according to Neimeyer and Hogan (2001), such methods are especially valuable in generating theory where little good theory exists, in revealing how people make meaning of events, and in moving toward a deep understanding of a particular phenomenon.

It can be stated that this study has yielded some interesting findings which could be used to endorse helplines and promote the practice of phone interventions. The quantitative and qualitative results of this study which were discussed above may potentially help improve the mental health services provided to trauma and loss survivors, not only at an operational level but also to understand the struggles of this population to seek help.

Strengths and limitations

'The only source of knowledge is experience'.

'If the facts don't fit the theory, change the facts'.

Albert Einstein

(Einstein, 2010)

The present study has several strengths and also a number of limitations. It should be noted, that several types of biases might have influenced the findings of this study.

The main strength of this research is its in-depth inquiry. There are number of features of this study which facilitated the depth of exploration required for this inquiry. First, the researcher's long-time involvement (sixteen years) in the service which was investigated, allowed capturing the service's history, philosophy and context. This enabled the researcher to focus on localized meanings and activities, and thus to provide a detailed understanding of the culture and the service.

Second, in this study, the researcher was familiar with the key informants from whom information was gathered, and that may be a good position to directly collect information. However, this familiarity may have biased the information collected. Future research may find different results if the researcher is unfamiliar to the studied population.

Third, the exploration of the research questions from a dual perspective, examining the view-point of the service users and the service providers, allowed getting a deeper understanding of the situation. This also provided an opportunity to compare these two view-points and to observe the similarities and the differences.

There are several factors to be considered, which recognized in-advance some limitations, and therefore an effort was made to minimize their effect as much as possible.

First, this was an investigation of one model, the LIM, which offers helpline support and assistance to Israeli citizens affected by trauma and loss related to war and terror. It explores psychological and social aspects of a human phenomenon in real-life situations, which arises complex research questions. Therefore, it applied qualitative methods, which according to Morse (1999); provide us with the means to explore such complex and chaotic real-life situations. It also applied mixed methods research, which forces the methods to share the same research questions to collect

complementary data, thus according to Yin (2009), it can permit investigators to address more complicated research questions and collect a richer and stronger array of evidence than cannot be accomplished by any single method alone. Yet, the limitation is that these findings are not generalizable to other helplines, thus it requires further research.

Second, this study was uncontrolled, because of ethical concerns about compromising the professional services provided to people in-need of mental health assistance. Additionally, this research faced challenges typical to any examination of helplines; the anonymous nature of the service and the sensitivity of the topic make it particularly challenging to engage users of the helpline in the investigation and to fully explore with all participants the ways in which the helpline had supported them. Therefore, in the absence of a control group, only tentative hypotheses can be generalized at best.

In order to counterbalance these two limitations, this research used triangulation, which is typically a strategy for improving the validity and reliability of research or evaluation of findings (Golafshani, 2003; Flick, 2004). The research applied two designs of triangulation; (a) triangulation was used by combining methods - using both quantitative and qualitative approaches (Patton, 2001; Cohen & Manion, 2000), and (b) using triangulation of several data sources in qualitative research, thus validating the data through cross verification (Bogdan & Biklen, 2006; O'Donoghue & Punch, 2003). Since triangulation gives a more detailed and balanced picture of the situation (Altrichter et al., 2013), this research used triangulation to achieve two targets - to produce understanding and to find credibility.

Third, part of the data was obtained retrospectively - the participants (specialists and clients) reported retrospectively on their experiences, in the interviews and letters. However, the participants were what Yin (2009) calls 'persons who are alive to report, even retrospectively, what occurred.

Additionally, case files provided concurrent data, to add to the scope of the research and the accuracy of the results.

Yet, it should be acknowledged that retrospective reports are less valid than concurrent observation (Seligman, 1995), thus limiting the results.

Fourth, this is a narrative research, during which the lines between therapy and research may blur. According to Romanoff (2001), the process of answering the researcher's questions changes the answer as participants construct their story anew. Therefore, Romanoff (2001) cautioned researchers to be acutely sensitive to their role in shaping the telling and in shaping the story that is told. It is possible that some of the findings are unique to the manner in which the researcher interpreted the data. Furthermore, some uniqueness can be attributed to the manner in which the interview questions were originally formulated, as well as addressed, in the interviews. In order to

cope with this challenge, care was taken during the course of the entire study to the researcher's influence of the data collected, and an effort was made to minimize this effect as much as possible.

Yet, replications and extensions with other participants and with other researchers to code the data as well as to formulate and direct the interview questions are warranted.

Nevertheless, within the qualitative tradition there is no expectation that the researcher will be objective. In fact, the concept of objectivity is viewed as somewhat of an illusion (Locke, Spirduso & Silverman, 2009).

Lastly, despite the limited generalizability of this study, the main findings presented in this thesis may resonate with other specialists, helplines, and organizations.

Implications for future research

'Progress lies not in enhancing what is, but in advancing toward what will be'.

Kahlil Gibran

(Gibran, 2013)

This thesis has yielded a number of findings which may generate future studies.

First, the helpline and its model, which are described here, were based on the premise of the psychological effects of the problematic security situation in Israel. The long continuous conflict in the Middle East seems extraordinary and therefore requires unique responses. However, recent years have shown that conflicts and terror are a global phenomenon which may affect different countries and societies. According to Ingham (1996), wars between states, terrorism and ethnic violence are commonplaces in the modern world. In fact, Husain (2012) suggests that more than 90 percent of the conflicts in the world today are in the name of religion or communities. Therefore, considering the contemporary political situation around the globe, the prevalence of mass violence and ethnic/religious conflicts – and their psychological, sociological and economical effects, it is suggested that further investigation of collective trauma which may lead to better understanding of the phenomenon and its impact, can be significantly beneficial for humankind.

Second, this study investigated the LIM and its contribution to the well-being of trauma and loss survivors treated by the NATAL helpline in Israel. Initial implementation of this model in the US, with American veterans and the African-American community in Chicago, shows promise of the possibility to knowledge-sharing and expansion of this model to different populations, different countries, and other mental-health problems. There is a need to further elucidate in future research the applicability of the LIM in different environments and situations.

Third, the finding that the majority of frequent callers, similar to helpline clients, are men, may provide an important understanding that can help to break the barrier which prevents men from receiving the assistance they need. Future research may explore men's willingness to use mental health services via phone compared to face-to-face services, so that it can be determined whether phone interventions may fill this gap and need.

Chapter 13

Model Adjustment

'To raise new questions, new possibilities, to regard old problems from a new angle, requires creative imagination and marks real advance in science'.

Albert Einstein

(Einstein, 2010)

This chapter presents an adjustment of the LIM (Longitudinal Intervention Model), which is instigated by this research. This research became eventually a circular process. It started as an exploration which produced a theoretical description of the LIM, which was intended to be investigated. Then an inquiry was made; first, by exploring existing theoretical knowledge residing in professional literature, and second by researching different sources of information related to the helpline, such as participants and documents. After findings were gathered and were put in context of the literature reviewed, the following step required revisiting the theoretical description of the LIM, which was produced in the beginning of the research (thus taking a circular pattern).

This whole process led to an adjustment of the LIM, which is an outcome of the quantitative and qualitative results. The results revealed a design portraying the framework of the LIM. This framework is depicted in the following figures (Figure 4 - Figure 8), in an attempt to present a model which shows the main elements of practice, and how those elements interact to produce the therapeutic process.

The LIM is visually designed as a pyramid, containing three planes: (a) *Forming an alliance*, (b) *Laying the foundation* and (c) *Working through*. The hierarchical pyramid format shows the relationship between the three aspects of the model. This suggests that these stages are built gradually, one after the other, and each level of the pyramid depends upon the level below it.

Changes in lower levels of the pyramid will effect change in higher levels, whereas the opposite is not necessarily true. The pyramid reminds helpers that they should emphasize the lower levels as they consider their work with clients.

Figure 4 illustrates the LIM:

Figure 4 - The LIM (Longitudinal Intervention Model)

The first stage is *Forming an alliance*. This stage characterizes the beginning of the intervention, and it is a first step - chronologically and essence wise.

Forming an alliance requires three steps: (a) Creating a safe and stable place, (b) Setting clear boundaries and (c) Reaching-out.

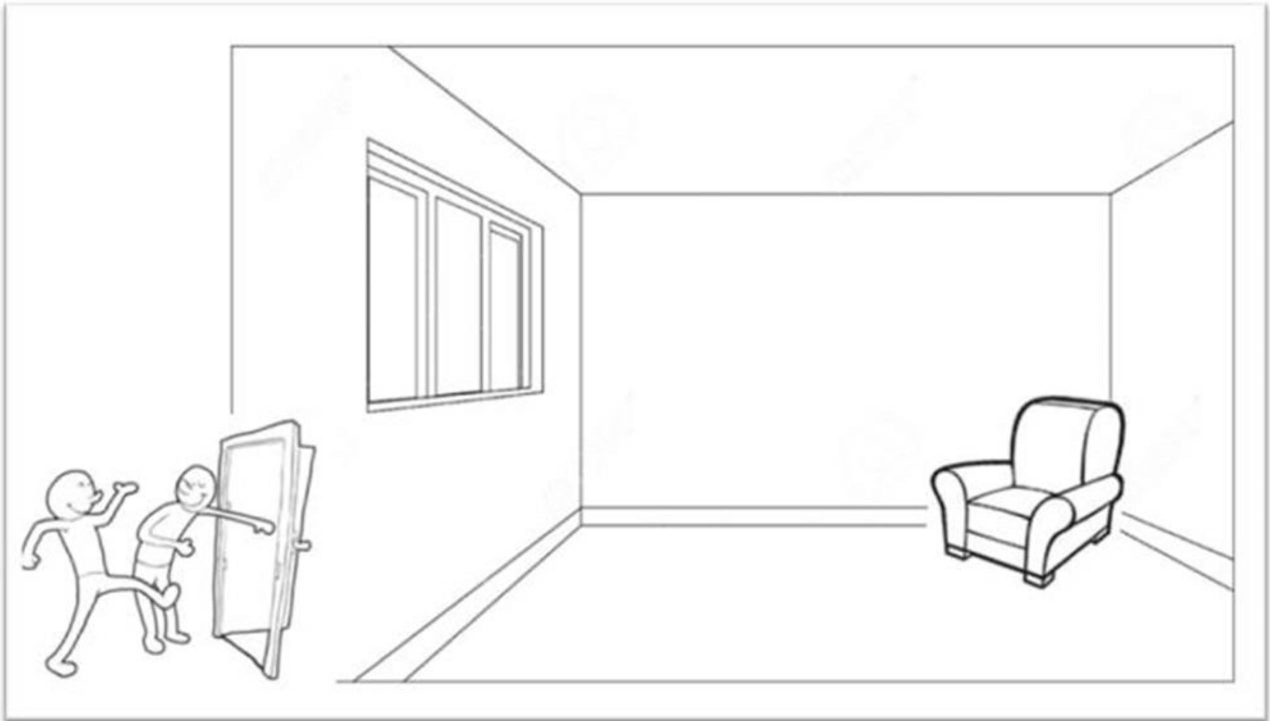
Figure 5 illustrates the stage of *Forming an alliance*:

Figure 5 - The stage of *Forming an alliance*

Illustrating the steps required to *Forming an alliance*, led to the understanding that this stage, in essence, is an attempt to build a virtual therapeutic room for the helpline callers.

Figure 6 illustrates the *Forming of an alliance*:

Figure 6 - The *Forming of an alliance*

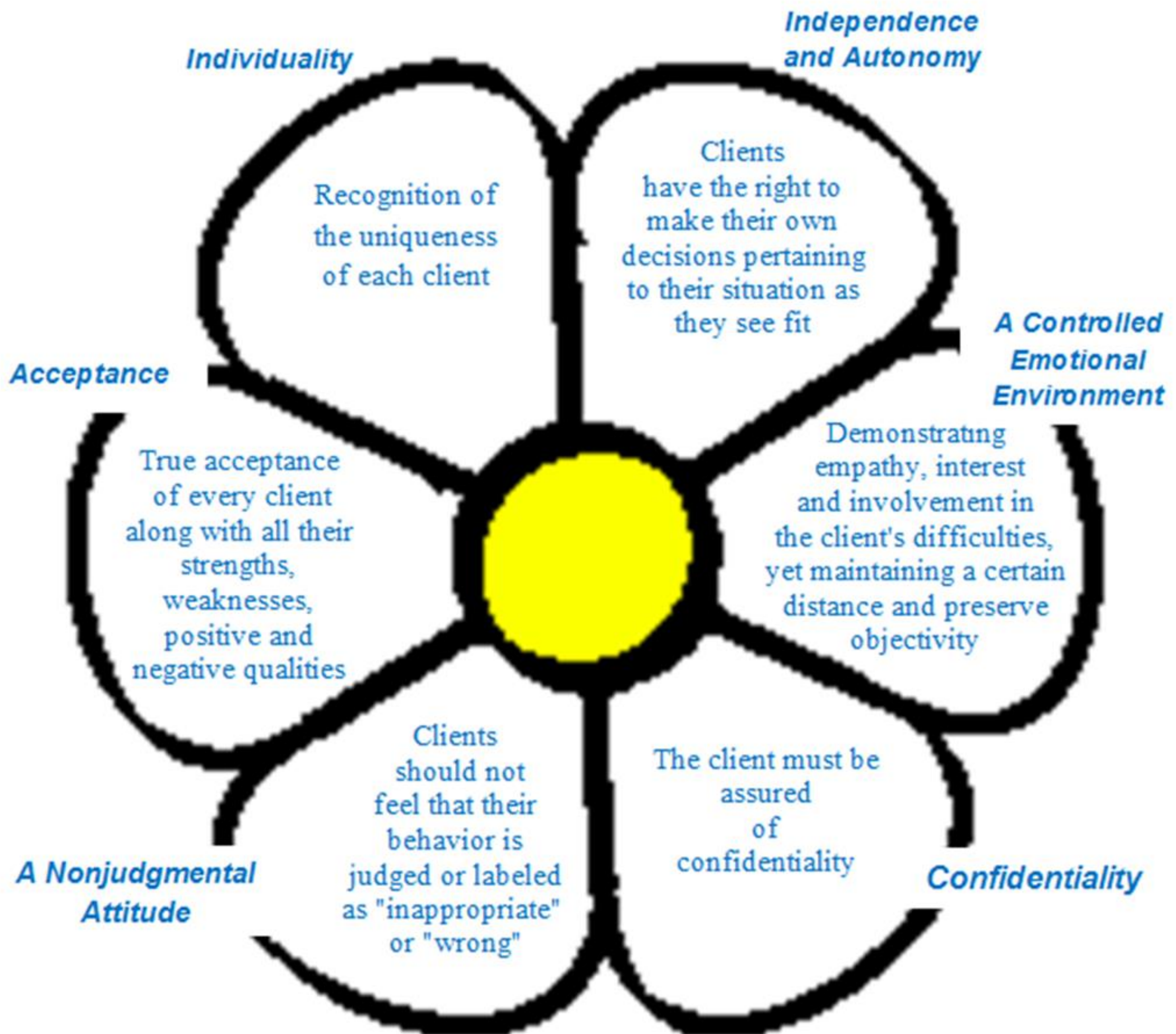


Once an alliance was formed, it is possible to create the second stage of *Laying the foundation*. This stage includes six attributes which are required in order to form a basis that will enable to move forward to the next stage.

The six attributes are: (a) Individuality - Recognition of the uniqueness of each caller, (b) Acceptance - true acceptance of every caller along with all their strengths, weaknesses, positive and negative qualities, (c) A Nonjudgmental Attitude - Callers should not feel that their behavior is judged or labeled as "inappropriate" or "wrong", (d) Confidentiality - The caller must be assured of confidentiality, (e) A Controlled Emotional Environment - demonstrating empathy, interest and involvement in the caller's difficulties, yet maintaining a certain distance and preserve objectivity, and (f) Independence and Autonomy - Callers have the right to make their own decisions pertaining to their situation as they see fit.

Figure 7 illustrates the stage of *Laying the foundation*.

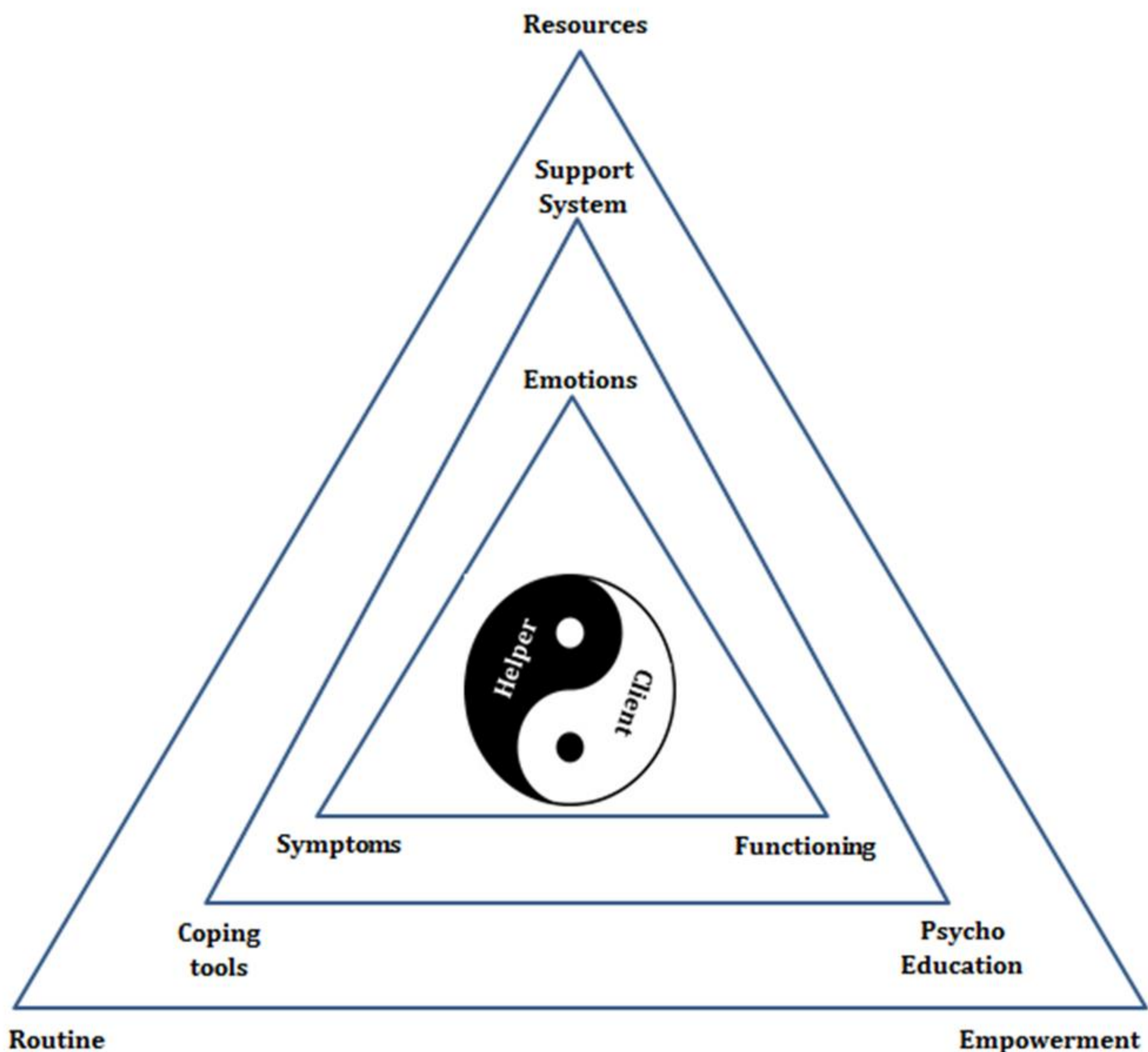
Figure 7 - The stage of *Laying the foundation*



After the foundation was laid, it is possible to lean on this foundation together with the alliance previously achieved in order to launch the therapeutic process – by *Working through* the client's struggles. During this third stage most of the intervention is made.

Figure 8 illustrates the stage of *Working through*.

Figure 8 - The stage of *Working through*



As illustrated in Figure 8, the core of the *Working through* stage is the bond and synergy of the client and the helper who labor together. The *Alliance* between them helps the client feel that the helper takes an active part during this process, in terms of his/her involvement and care. The helper also expresses support by conveying the necessary attributes which *Lay the foundation* to their joint work. This is a cooperative journey, in which the bond between both parties serves as the grounds and catalyst of the process.

The process involves work which spreads over three fields, each of them comprises of three spheres.

The first field covers three fundamental spheres of struggles which are typical to trauma and loss survivors: emotions, symptoms and functioning.

The next field is the second layer of work done in each sphere, and it involves keys aimed to enable the client to deal with the struggles of the previous layer. The keys are: coping tools to help with symptoms management, support system to help with emotions management, and psycho-education to help with functioning management.

The focus of the work on this level is gaining control over the paralyzing emotions and symptoms which lead to the functioning impairment.

Once the client experience an enhanced control over his life and better ability to cope with his struggles, then the third layer, which focuses on rehabilitation, can begin. The third field consists of three stabilizers: routine, resources and empowerment.

In summary, the intervention proposed by the LIM, is organized along three main therapeutic lines: (a) acquiring coping tools to gain control over the identified symptoms in order to maintain routine, (b) identifying and understanding emotions in order to create a support system which serves as a resource one can lean on, and (c) obtaining psycho-educational knowledge that helps to better functioning which leads to empowerment.

Yet, it is important to remember that the intervention itself, which is the stage of working-through, should rely on the former two stages, starting with the formation of alliance and followed by the laying of the foundation.

This hierarchical configuration has implications for helpers, especially in cases that do not seem to be going well. Namely, when problems exist in one level of the pyramid, the solution is often found at the underlying level. For example, when clients are not making progress or seem resistant to the interventions offered, instead of changing models or interventions, the model suggests that the helpers should first evaluate the quality of the alliance they have developed with their clients and the foundation they have laid, so they can consider whether there is a need to strengthen it.

Lastly, in addition to suggesting a treatment modality, this model also recognizes the invaluable importance of the therapeutic relationship, and acknowledges that it is the heart of treatment. It also offers a suggestion for practicing it in tele-medicine settings.

PART VIII

Summary and Conclusions

Chapter 14

Summary

Summary

'Thus the sum of things is ever being reviewed'.

Lucretius

(Gillespie & Hardie, 2007)

This chapter summarizes the key findings of the study and presents a synthesis of the main insights arising from this inquiry. The objective here is to provide a cohesive picture of this exploration, focusing on the main theoretical and practical implications of this study.

According to Romanoff (2001), as the 20th century draws to a close, a postmodern consciousness is enriching scholarly inquiry, presenting a forceful, compelling alternative to the logical positivist paradigm that has dominated much of psychological theory, research, and practice since its inception as a discipline. Contemporary scholarly inquiry emphasizes local knowledge and the creation of meaning over "discovery" of broad, generalizable truths that exist in an observable reality.

Additionally, according to Yin (2009), the philosophical and theoretical principle of health care is holism, but it is also the bane of the researcher. Reality dictates that phenomena be researched from the micro-analytic to the most abstract levels and explored from the perspectives of the client, relatives, and the service providers. Therefore, this study involved a multidimensional inquiry to explore various facets and practices. However, similar to some naturalistic present-day studies, the lines between research and practice are blurred as both come to rely on narrative methods as an important source of data. Yet, narratives are not only important and fruitful sources of information, but they are also powerful agents of change in both psychotherapy and, perhaps inadvertently, in research endeavors.

Although this research investigated a specific service which is provided by a specific organization – NATAL, it dealt with a broad universal problem – the toll of trauma and loss related to war and terror. Naturally, the research originated from the Israeli experience - since the War of

Independence, in 1948, the Israeli population has paid a heavy toll as the main target of ongoing war and terrorism. Indeed, recent studies have shown the adverse effects of exposure to terrorism (Bleich, Gelkopf, Melamed, & Solomon, 2006; Gelkopf, Solomon, Berger, & Bleich 2008; Shalev, Tuval, Frenkiel-Fishman, Hadar, & Eth, 2006), war (Hobfoll et al., 1989; Cohen & Yahav, 2008) and chronic missile and mortar attacks (Dekel & Nuttman-Shwatz, 2009; Besser & Neria, 2009) on civilian adults, as well as on children and adolescents of various ages (Berger Pat-Horenczyk, & Gelkopf, 2007; Gelkopf & Berger, 2009; Pat-Horenczyk, 2005; Sagy & Braun-Lewensohn, 2009; Solomon & Lavi, 2005). Consequently, many psychosocial and mental health services have been set up to help the Israeli civilian population cope with trauma due to war and terror (Baum, 2005; Ben-Gershon, Grinshpoon, & Ponizovsky, 2005; Berger, 2005; Laor, Wiener, Spirman, & Wolmer, 2005).

However, war and terror are not an extraordinary Israeli problem - they are human phenomena which occur in different parts of the world. Nevertheless, the September 11, 2001, attacks on New York and Washington, DC, the aftermath of these assaults, and their ripple effects, have altered the world dramatically; if residents of the most important cities in the most powerful nation on earth cannot be free from the horrors of terrorism, no one, many have felt, can feel safe anymore (Dechesne & Kruglanski, 2004). During 2015-2016 (while writing this thesis), numerous terror attacks occurred around the globe, among which in Europe: eight attacks in France (Paris and Nice), the Brussels suicide bombings, and the Berlin Christmas market attack.

Studies on the impact of war and terror around the world have identified a range of adverse mental effects on civilians, including posttraumatic stress symptomatology (Rubin, Malkinson, & Witztum, 2005; Silver, Holman, McIntosh, Poulin & Gil-Rivas, 2002), anxiety and depression (Hobfoll, Tracy, & Galea, 2006), as well as functional problems (Miguel-Tobal et al., 2006). Research suggests that both adults who experienced the attack directly (Bleich, Gelkopf, & Solomon, 2003) and those who experienced it indirectly, through the media (Schlenger et al., 2002; Updegraff et al., 2008), show elevated levels of distress, pathology and a lowered sense of security. The impact of terror and war has not been limited to the adult population, but encompasses all age groups, including adolescents (Gil-Rivas, Holman, & Silver, 2004), children (Hoven et al., 2002; Koplewicz et al., 2002; Pfefferbaum et al., 2003), young infants and toddlers (Chemtob, Nomura, & Abramovitz, 2008; Wang et al., 2006). There is now a growing number of studies that have found that when adversities occur, their negative effects can be long lasting, and that lifetime adversity was associated with higher global distress, functional impairment, and PTSD symptoms, as well as lower life satisfaction (Seery et al., 2010; Skitka, Saunders, Morgan, & Wisneski, 2009).

In the past, the intensity of the Israeli experience with war and terror led to extensive research of trauma and loss, which contributed to the development of this field (Besser & Neria, 2009; Besser & Neria, 2012; Dekel et al., 2005; Gil et al., 2016; Greene et al., 2016; Keinan, 2012; Malkinson et al., 2006; Rubin, 2013; Rubinstein, 2003; Sasson-Levy, 2008; Shalev et al., 2006; Schellekes & Dekel, 2001; Shrira et al., 2012; Tamir & Haimov, 2005; Tuval-Mashiach & Shalev, 2005; Witztum &

Kotler, 2000; Zakin et al., 2003; Zertal, 2002). Hopefully, this research can also add to the accumulated knowledge by exploring the needs of trauma/loss survivors, and also by investigating a service aiming at helping them achieve better functioning and well-being. The findings of this research are tentative but are an important first step in improving the understanding of the needs of this population, its barriers and inhibitions regarding seeking and accepting mental health services, and possible factors which can promote the personal and social situation.

Clearly, in our times, insight into the phenomena of terror serves a greater purpose than the mere gratification of intellectual interest. Understanding what influence existential concerns constitutes not only a pertinent topic for scientific inquiry but also a direly needed area into which insights are needed given the current world's turmoil (Dechesne & Kruglanski, 2004).

Therefore, although this research examined the concept of 'national trauma'/'collective trauma', and provides literature review of this subject and some relevant findings, further research is needed to investigate this phenomenon. These terms reflect a recent integrated view concerning trauma of the fields of psychology and sociology. Some scholars suggest that the understanding of trauma cannot be restricted to the intrapsychic processes of the individual sufferer because it involves highly relevant social and cultural processes. Likewise, the consequences of massive trauma afflict not only individuals but also social groups and cultural formations (Karenian et al., 2011; Mays, Bullock, Rosenzweig, & Wessells, 1998; Poulin, et al. 2009; Rimé, Páez, Basabe, & Martínez, 2010; Rimé, Kanyangara, Paez, & Yzerbyt, 2012; Saul, 2013; Seery et al., 2008; Updegraff et al., 2008; Wirth, 2013).

Additionally, of all the official diagnoses listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), PTSD is unique in that it involves locating the cause of adverse psychological symptoms in worldly experience (APA, 1994, pp. 424–429; Young, 1995). It requires establishing a causal link between an experience held in common by a group of individuals and the psychological symptoms they share as a result of that experience, socializing both the causes and manifestations of mental disorder in a unique way. Within the context of modern diagnostic psychiatry, the PTSD diagnosis stands out as a unique narrative of social illness (Shephard, 2000).

According to DeGloma (2011), the PTSD diagnosis is a powerful cultural script that various individuals and interest groups use to interpret mental health symptoms while attributing psychological consequences to social causes as opposed to problems rooted in the individual's psyche (as with psychoanalysis) or neurophysiology (as with modern diagnostic psychiatry). Social movements, professional mental health organizations, and individual advocates work to shape the broad cultural understanding of trauma in general and PTSD in particular. Given their commitment to identifying the social causes of psychological distress, they present a challenge to ''the bio-psychiatric medical model'' (Cooksey & Brown, 1998) of diagnosis that has dominated the field of psychiatry for the past three decades.

DeGloma (2011) calls these mental health organizations and individual professionals 'trauma carriers' and suggests that they engage in significant social memory work and collective identity work, define social problems, and practice social activism as they address the causes and consequences of psychological suffering. This definition is suitable to the activity of NATAL and the work of this researcher. In fact, one of the aims of this research is to emphasize such culturally and socially sensitivity to this psychological work, and to help transform the social view of war/terror related trauma and loss from "personal troubles" into "public issues" (Mills, 2000). It is my personal and professional belief that collective trauma and loss are connected to a larger context (than the personal individual experience), and that is the reason for the damage to social ties and functioning. Therefore, any healing and rehabilitation processes need to also occur in a social and communal environment. A helpline offers a unique opportunity to engage in an initial renewed social connection, without it being too intimidating or overwhelming. This connection with the helpline can then serve as a first step in a longer, more profound journey – instigating more social and communal connections (new or renew), and a bridge to therapy.

However, seeking and receiving help is no simple task. The body of research indicates that receiving help is a complex psychological phenomenon. it is a negative, threatening experience associated with unfavorable responses (Addis & Mahalik, 2003; Burrick, 2014; Cheng, Kwan, & Sevig, 2013; Clement et al., 2015). Research indicates that receiving help from a socially close similar other (i.e., a friend) arouses comparison stress and is therefore a self-threatening experience (Fisher & Nadler, 1974; Fisher, Nadler, & Whitcher-Alagna, 1982; Nadler, Fisher, & Streufert, 1976). Therefore, many people will not ask for help from their friends and family, although that is their natural support system. The problem is even greater, since seeking help from a professional is even harder – the fear of being stigmatized is one reason why nearly half of the 60 million Americans with serious mental illness do not seek treatment (Corrigan, Druss, & Perlick, 2014; Kessler, Chiu, Demler, & Walters, 2005; Wang, Whitson, Anicich, Kray, & Galinsky, 2017), and it has been found to be the reason that almost half of the people surveyed do not seek help with their disorder (Thornicroft, Rose, & Kassam, 2007; Whitley, 2017). Moreover, since 1990, there has been no change in the stigma attached to mental illness, and in some cases, a worsening of attitudes has been formed (Haqanee, Lou, & Lalonde, 2014; Whitley, 2017). In this respect also, a helpline can be a good solution, since it allows people to seek help from strangers, thus enabling an experience which is much less self-threatening. Also, being a para-professional service it is much less stigmatizing and thus enables more people to receive help.

Similar to many qualitative researches, this study aims to provide an understanding of the researcher which presents reality/real-life situations in a way which is uncommon and new. Therefore, according to Shlasky and Alpert (2007), this is considered a theoretical innovation. The novelty of this research is also based on the fact that studies on longitudinal telephone interventions are limited, both in number and in the provision of a theory or a model of operation. Despite the growth of helplines, it

is not necessarily the case that theorists have had the opportunity to achieve a deep understanding of what it means to cultivate a long-term relationship and to perform a therapeutic intervention, by para-professionals over the phone. The present study attempts not only to investigate an active helpline, but also to introduce an intervention model and assess its outcomes.

This research is dealing with contemporary psychological and social phenomena, which pose complex dilemmas to individuals, families, communities and societies. According to Cyrulnik (2009), as society becomes more organized, individuals become dissociated from one another. As their conditions improve, human beings need each other less and less. Contemporary Western society is characterized by loneliness (Casey, 2002), therefore, the dissolution of bonds with others increase the vulnerability to trauma.

Additionally, according to Mackay (1999), the information revolution challenges our patterns of life in ways which are at least as profound and far-reaching as the Industrial Revolution of 200 years ago. Recent technological advancements have touched most professions and this trend is also apparent in the mental health service, which is evident by the increasing number of helplines and tele-counselling services.

According to Husain (2012), modern technology and communications have greatly reduced distances across the world, but the closeness, thus produced, is purely physical in nature. He also suggests that modern technology may have bridged certain gaps, bringing the external world closer together, but the task of bringing unity into the internal world is yet to be accomplished. Similarly, according to Mackay (1999), by creating electronic connections in cyberspace, people were introduced to the notion of the global village, but this is a community in need and in search of reconnection.

However, the results of this study may indicate that the universality of human experiences and struggles are the basis of commonalities, and that there exists a relation between individuals, personal processes, social phenomena, societies and cultures. This study attempted to explore and evaluate a service designed for the Israeli population, assuming there are cultural and situational aspects specific to this population and this service. During the course of the research, emerged some universal phenomena, and other potential generalizations, which indicate that despite the understandable differences, there are also many similarities, and that phone interventions can very possibly bridge not only external, physical distances but also psychological, societal and cultural differences.

The model presented in this study attempts to offer a balanced answer to this contemporary dilemma – the possibility to use technology, phones, which is compatible to present-day habits, and harness it to overcome the modern barriers which lead to estrangement.

Norcross and Wampold (2011) suggested that as the field of psychotherapy has matured; using an identical therapy relationship and treatment method for all clients is now recognized as inappropriate. The efficacy and applicability of therapy will be enhanced by tailoring it to the unique needs of the client. This is consistent with the aims of the service and model which are investigated here. They originated from the sensitivity and recognition of the unique needs of trauma/loss survivors, and the barriers that prevent them from seeking help. They were tailored to respond to those needs and overcome some of those barriers, while utilizing the benefits of technology, the advantages of the phone, and by drawing from the guidelines of therapy, crisis intervention and tele-medicine.

Unlike much psychotherapy that was derived from theories of personality, crisis intervention was developed by practitioners in applied setting who were seeking effective responses to individuals in crisis (Kalafat, 2012). Based on an experience of twenty three years, it is my belief that every helpline, regardless of its orientation or philosophy, has to maintain some basic principles of crisis interventions. People who call helplines are always in some crisis, and in need of an immediate response. According to Kalafat (2012), crisis intervention is an ecological approach in which we must look to internal resources and gaps of the individual, and the demands and supports of the environment, to identify both the causes and the possible resolution of the crisis.

Once this assessment is made, then according to the helpline's orientation or philosophy an intervention can be planned – which may be a single crisis intervention (as most helplines offer), or a longitudinal intervention, as the LIM suggests.

The NATAL helpline that was investigated offers a service which isn’t easily defined. The field of tele-medicine offers different and diverse services, and there is a disagreement among scholars regarding the definition, philosophy and practice of these services (Baker & Bufka, 2011; Brenes et al., 2011; Campos, 2009; Harwood et al., 2011; Williams, 2000).

Moreover, the NATAL helpline and the LIM provide a service which contains elements that are more typical to therapy than to crisis intervention, and also include principles which are considered unacceptable to tele-medicine.

Yet, this service can be included by the definition of a helping profession as suggested by Miller and Considine (2009): 'helping professions deal with the provision of human and social services'. Another definition is that a helping profession is a professional interaction between a helping expert and a client, initiated to nurture the growth of, or address the problems of a person's physical, psychological, intellectual or emotional constitution (Graf, Sator, & Spranz-Fogasy, 2014). Therefore, although the NATAL helpline and the LIM aren’t involving mental-health professionals – they can be considered as providing a service of a helping profession.

Although an exact definition may be difficult to achieve, it is important however to identify the clientele of the helpline and its impact, then to identify the therapeutic practices involved in this model, and if possible, to relate them to mental-health practices.

The helpline impact

'Impact involves getting results; influence is about spreading the passion you have for your work'.

Robin S. Sharma

(Sharma, 2006)

First, the present research aimed to explore the impact of NATAL's helpline. Quantitative and qualitative methods were used in order to identify the population which is affected by the helpline, through ascertaining the characteristics of calls, callers and clients. The relatively large number of callers and clients, who used the service and the pattern of the incoming calls, indicate that (a) there are many people in Israel in need of mental health and emotional support - after they experienced trauma/loss, and (b) helplines can provide services to a large number of people – during crises and during the aftermath.

The pattern of the incoming calls also confirmed the important role of helplines during crises, when many people are in need of immediate temporary assistance, and find helplines to be a convenient accessible solution.

Second, past research showed that helplines' callers have some universal characteristics - many of them are relatively normal people, experiencing emotional distress, whose sense of pride and integrity is threatened by coming to an agency. Their fear of a loss of self-esteem acts as a barrier to seeking help openly (Williams & Doubs, 2012). Similarly, in this research the callers were described as people facing a critical moment or a crossroad, which leads them to experience distress, internal chaos and a sense of a dead end. This view of callers indicates the non-stigmatic attitude of this service, which is bound to be sensed by the callers themselves. It proves once more the necessity of the mental health profession to search for and develop non-stigmatic approaches and service-deliveries in order to enable more people to receive help.

Also, researches indicate that most people who contact helpline are unwilling to seek professional mental health services (e.g. Gil, 2002; Mohr et al., 2005; Mozer et al., 2008; Burgess et al., 2008; Bee et al., 2010; Williams & Doubs, 2012). However, Coman et al. (2001) maintained that patients who oppose attending therapeutic sessions can benefit from telephone assistance until they are ready for face-to-face therapy. Consistent with these findings, the present research also indicates that providing a mental health service which is less stigmatic was proven to be a significant factor in help-seeking behavior – not only it enables many more people to receive help, it also can serve as a bridge to therapy. A longitudinal phone intervention can be the first step to promote a process which helps people to realize they need therapy and overcome their barriers and resistance. Therefore, helplines can serve as an essential initial point of intervention, with potential to motivate callers to seek/accept longer-term treatment.

Additionally, this research proposed a different perspective to a known phenomenon which helplines need to cope with; frequent callers. Frequent callers, similar to helpline clients, have multiple contacts with the helpline, and they appear to need more assistance than a single call (e.g. Kinzel & Nanson, 2000; Gilat & Latzer, 2007; Ingram et al., 2008). The literature shows that most helplines treat frequent callers as a burden which is hindering the work of the helpline and the specialists. Moreover, the literature also shows that these are the most problematic callers, who do not improve, and will continually be dependent with the helpline.

However, this research indicates that the attitude of the helpline towards callers who need more assistance might also affect their situation. Treating people who need more assistance differently – addressing them as clients and not as problematic (frequent) callers, and more than anything tailoring the service to accommodate to their needs – has proven to be successful – contrary to past researches, this research showed that they improve following the helpline intervention.

Third, the unusual finding that the majority of the helpline clients are men (although the majority of callers are women), and that most of them are married or cohabit with their non-married partner, indicates that helplines may serve as an important resource for men, who were found less likely to seek mental health services (e.g. Addis & Mahalik, 2003; Bertakis et al., 2000; Clement et al., 2015; Galdas et al., 2005; Hatchett & Park, 2004; Möller-Leimkühler, 2002; Oliver et al., 2005; Wang et al., 2013). Also, it indicates that people are less inclined to rely on their support system when coping with trauma and loss, and therefore can benefit greatly by a service which can help compensate that. Finally, it indicates that such a service may be crucial for traumatized men, whose gender and emotional injury may prevent many of them from receiving any other kind of help.

Lastly, this study provided an observation made by the participants, that the helpline has a larger impact on the community and society – larger than the clients and their families. It indicates that the helpline produce social legitimacy to seeking help and to receiving mental health services, by raising

awareness. The existence of benevolent social services, which advocate and provide some needs of individuals, and promote legitimacy and acceptance, has significant impact on social cohesion and resiliency (e.g. Anheier, 2013; Edwards, 2013; Tester, 2014).

The therapeutic approach

'You talk when you cease to be at peace with your thoughts'.

Kahlil Gibran

(Gibran, 2013)

First, the treatments available for PTSD span a variety of psychological categories (Mott et al., 2014). Similarly, there are variety of psychological approaches and treatment techniques used at the helpline. This may be a reflection of the diverse manifestation of clients' (trauma/loss survivors) struggles and needs. Also, the helpline provided interventions which included the two main groups of coping strategies within the trauma and loss treatments, which are emotion-focused strategies and problem-focused coping strategies (Littleton et al., 2007). This may indicate that phone interventions can include many of the current popular psychological approaches and treatment techniques, despite the non-traditional characteristics of the intervention.

Additionally, Neimeyer et al. (2010) suggested that in psychotherapy, the client enters treatment to get help overcoming a problem, symptom, interpersonal conflict, or the emotional distress that these entail. Then, different approaches to therapy orient to this task differently, promoting more adequate coping with stressful situations, developing cognitive skills in counteracting self-defeating thinking patterns, promoting more satisfying interactions with others, interpreting historically maladaptive patterns, and so on (Neimeyer et al., 2010). Similarly, it can be said that this description apply to helpline callers, and that the phone intervention provides some of these therapeutic tasks.

Second, another important aspect to be considered is that emotions and emotional work occupy the central position in psychotherapeutic practice. Despite numerous psychotherapeutic traditions and schools, working with and through clients' emotions appear to be the main tool through which the desired change can be accomplished (Graf & Pawelczyk, 2014).

According to Reay (2004), emotions need to be considered in terms of how they work, in concrete and particular ways. Therefore, survivors of trauma and loss, who are flooded with intense emotions (Attig, 2001; Calhoun & Tedeschi, 2001; Dechesne, 2012) need to cope with these intense emotions, and to find a coping strategy. Talking with an attentive and empathetic person can be a good coping strategy. Regarding the effects of talking, McLeod and Wright (2009) suggested that talk works as a confessional practice and a measure of good relationships. Talk is a technique that promises the prevention and alleviation of distress. Additionally, feelings-talk is an endemic characteristic of psychotherapy, where emotional healing occurs through communicative practices such as self-disclosure and communication of emotions (Pawelczyk, 2011; Voutilainen, Peräkylä, & Ruusuvuori, 2010). Therefore, emotional work emerges as one of the curative and emancipatory factors in psychotherapy (Graf & Pawelczyk, 2014).

To conclude, the existing literature and the results of this research indicate that sharing one's emotions is beneficial to one's well-being and can assist in coping with distressful emotions that are related to trauma and loss (Davis, 2001; Kalafat et al., 2007; Sherman, Harris, & Erbes, 2015). Since many of trauma/loss survivors are reluctant to disclose their feelings to family and friends (Kalafat, 2012; Neimeyer et al., 2010; Nadeau, 2001; Zertal, 2002), it is suggested that a service which can serve as an attentive ear may be a good solution.

Third, the present research supports past findings which showed that therapeutic elements such as creating a safe place, providing understanding/empathy/containment (non-judgmental), encouraging emotional expression, offering new perspectives/insights/ realizations and guidance – are the significant components which contributes to successful treatment (e.g. Ayalon & Lahad, 2001; Baumeister et al., 2014; Bodie et al., 2012; Carey et al., 2009; Gabbard, 2000; Johansson & Andersson, 2012; Moro et al., 2012; Rogers 1961; Roter et al., 2006; Shedler, 2010; Vermeire et al., 2001; Weger et al., 2014; Winnicott, 1965; Young et al. 2003). These elements were found to be included in the helpline intervention, thus suggesting that although the helpline intervention isn't defined as therapy per se, it certainly is consistent with therapeutic practice.

Also, according to van Loon and van Dijk (2015), dialogue and reflection are essential in the process of opening up to new ideas and possibilities. Therefore, if treatment is aimed at generating change in addition to relieving distress, then it should encourage generative dialogue, which enables the emerging of new meaning (Hawes, 1999). This emphasizes the need to create a reciprocal and mutually reflexive process which engages two people, due to the need that somebody else will ask a question that can lead to new insight (van Loon & van Dijk, 2015).

Furthermore, all the therapeutic elements mentioned above, are produced in an environment created by the relationship between the therapist/helpline specialist and the client. Historically, psychoanalysts viewed interactions between client and therapist as projection, whereby acceptance

from the therapist provided a foundation for positive transference (Horvath, 2000). Therefore, the therapeutic relationship was subject to interpretation rather than being seen as a genuine interpersonal relationship. Although Freud (1912) advocated engaging collaboratively with patients (Gelso & Samstag, 2008), Rogers (1957) was the first to articulate nonmedical healing as a relationship issue. The humanistic psychotherapy movement (e.g., Bugental, 1987; Jourard, 1971; Rogers, 1957) advanced the importance of the therapist–client relationship.

Rogers (1951, 1957) asserted that the therapist's ability to be empathic and congruent and to accept the client unconditionally were not only essential but sufficient conditions for therapeutic gains (Horvath & Luborsky, 1993). This research attempted to investigate the therapeutic gains of the phone intervention, by exploring the perspectives of the helpline specialists as well as the clients. The results support Rogers's theory, showing that nonprofessionals (helpline specialists) can instigate significant therapeutic gains by being empathic, congruent and accepting of the client. These results are not only an additional support of the contribution of helplines operated by nonprofessionals, but can also indicate that it can be beneficial to consider the possibility of utilizing helplines to provide mental health services providing more than crisis intervention. The results show that it is possible to provide a mental health promoting intervention, by phone, of well-trained nonprofessionals, to assist trauma/loss survivors in achieving better functioning and well-being.

Forth, these results may also support the findings of many scholars, that the therapeutic alliance is a factor that may be responsible for the changes and improvement of clients. According to Horvath and Luborsky (1993) and Norcross and Wampold (2011), a major discovery in psychotherapy research of the past two decades has been the consistent finding that different therapies produce similar amounts of therapeutic gains. In fact, both meta-analyses and quantitative reviews of therapy outcome literature find that the therapeutic alliance accounts for roughly 30% of the variance in client outcome (Lambert & Barley, 2001; Safran & Muran, 2000; Wampold, 2001), while therapy techniques account for between 5% and 15% of outcome variance (Beutler & Harwood, 2002).

Many researchers have interpreted these results as an indication that variables common to all forms of psychotherapy may be responsible for a large part of a client's improvement - that is, there are generic elements common to all forms of therapy, alliance being such a pan-theoretical factor.

However, in the context of helplines, Landqvist (2014) suggests that the basic relationship between caller and advisor is that of an unknowing person seeking advice from an expert. This may be true for some helplines, yet it is certainly inconsistent with the intent of one of the pioneer helplines in the world, the Samaritans, which aimed at providing a new model of social support for people in distress and not an expert advisory service (Karon, 1991; Raviv, 2000). Similarly, according to Firth et al. (2005), talk is the help of helplines (not advice). Unfortunately, since almost all helplines provide a one-time service, the relationship between the helper/specialist at the helpline and the caller/client was not given the attention needed and wasn't investigated as was the therapeutic alliance in face-

to-face therapy. The results of this study indicate that there was a consensus among all the participants, clients and specialists alike, who emphasized the importance of the therapeutic relationship and their positive impact.

To conclude, the NATAL helpline and the LIM perceive the helpline as a service which provide an opportunity for distressed people to share their emotions and work-through to improve their distress and their struggles, in order to reach better well-being and functioning. This service is delivered by trained specialists who are nonprofessionals, and they assume an attentive empathetic role and do not see themselves nor wish to be seen as experts. Moreover, the training provided to the specialists specifically emphasizes the belief that the caller/client is the expert since they know themselves best; therefore the specialist's role is to empower them to look for their own solutions.

Fifth, The present research findings suggest that there are additional two factors which are included in the therapeutic approach of the helpline despite being unusual in conventional therapy, which significantly influence the outcomes of the intervention; the uniqueness of the medium – phone, and the reaching-out component which is unique to the LIM.

The results of this research are consistent with past findings highlighting the unique advantages of using the phone for mental health interventions. The three main advantages are (a) the liberating experience and protection as a result of the anonymity which helps clients to reduce their inhibitions and overcome difficult feelings such as shame and guilt, (b) the ability to focus inward as a result of the absence of external stimuli and distractions, and (c) the anonymity of the helper allows clients to see themselves and their image in the helper (projecting their positive qualities onto the helper), thus creating the ideal specialist for them (e.g. Lester & Rogers, 2012; Meissner, 2002; Segal, 2012; Skårderud, 2003; Spillius & O'Shaughnessy, 2013; Tansey & Burke, 2013; Williams & Doubs, 2012). Despite the growth of helplines and the accumulative researches' results testifying of their efficacy, many mental health professionals are still reluctant to engage in phone interventions or acknowledge their benefits. Moreover, training institutions also ignore this phenomenon and do not teach future mental health professionals the practice of tele-medicine. This research indicates that the unique characteristics of the medium are perceived by the service providers and the service users as responsible for some of the positive outcomes of the intervention – a finding which is worth the consideration of mental-health professionals.

Sixth, one of the main elements of the LIM is reaching out. This is a concept which is common and acceptable in community work and social work, but isn’t conventional or considered suitable in therapy or helplines. This is probably the reason for the lack of interest or research regarding reaching-out in the professional literatures dealing with therapy and telemedicine.

Additionally, consistent with past researches, this research found that the helpline callers and clients are people who frequently dislike mental health services, are alienated from wider society and struggle on alone (e.g. Coombs & Dillon, 2002; Cupitt, 2009; Wright et al., 2003). Additionally, scholars found that the main ramification of trauma on victims is regressing to a more primitive psychological functioning, and they often experience lack of energy which inhibits their ability to initiate or actively pursue goals (Davenson, 2004; Schellekes & Dekel, 2001). It is obvious that engaging this population with mental health services is almost an impossible task. Therefore, the model of the phone intervention which was investigated in this study (the LIM), is based on reaching-out, which is actively offering treatment to people who need much support (e.g. Van Citters & Bartels, 2004; Nxumalo et al., 2013; McGivney, 2000). The present study showed that reaching out indeed requires a less active position of people, thus enables more reluctant clients to successfully engage in the helpline.

It is difficult to find scholarly support for this view, especially related to helplines. An exception can be found in the findings of Combs (2007), who wrote about his experience of mental health interventions by telephone with Katrina survivors. He found that callers indicated experiencing a significant sense of relief just knowing that someone cared enough to listen. Additionally, callers were very appreciative when re-contacted (reaching out), and stated how validating it was to them that they had not been forgotten. Combs's (2007) findings reinforce the findings of this research, which indicate that clients experience the reaching-out to them as indicating care and concern – which is a therapeutic element by itself (e.g. Batson et al., 2015; Jordan et al., 2016; Kalafat, 2012). Also, the consistently of the reaching-out in itself is perceived by the clients as perseverance of the helpline specialists, which makes them feel that despite their resistance, the specialist is committed to them and to helping them.

To conclude, the element of constant reaching-out to clients suggested by the LIM, however uncommon to therapy and helplines, was found to be a crucial component which is viewed by clients as very helpful. This data seem to have a potential to be used by social scientists in innovative ways to explore social needs and trends - considering the characteristics of modern life which decrease human contact and diminish help seeking of mental health services, perhaps there is a need for a change in some of the conventional practices of mental health services to include reaching-out. It might be beneficial for clients if mental-health service providers were to include reaching-out in their therapeutic approach, thus engaging more reluctant populations.

The therapeutic outcomes

'Start by doing what's necessary; then do what's possible; and suddenly you are doing the impossible'.

St. Francis of Assisi

(Chesterton, 2008)

The present study showed that interventions done by the telephone specialists, according to the LIM, result in significant therapeutic impact: there was a general decline in functioning problems, an improvement in the severity of symptoms of the clients, and a reported improvement in clients' well-being and better social/familial relationships. This is conforming to the existing literature suggesting that the outcomes in PTSD professional therapy are symptoms reduction, improved quality of life and improved functioning (e.g. Foa et al., 2008; Mott et al., 2014; Schumm et al., 2015).

Additionally, this study showed that the helpline intervention enables clients to overcome one of the barriers obstructing recovery, which is their difficulty to share the experience and their emotions with their family and friends (e.g. Bonanno & Kaltman, 1999; Cyrulnik, 2009; Herman, 1994; Grand, 2000; Silverman, 1986). The present study demonstrated that clients succeeded to break the silence regarding their traumatic experience, by talking with the helpline specialist as a first step of the revealing process, which then enables them to do the same with their relatives.

The therapeutic outcomes presented here indicate that the LIM may be an additional or alternative mode of mental health service for trauma/loss survivors, which can help promoting their recovery or well-being.

Previous researches and our field experience show that many people who call helplines, especially trauma and loss survivors, are not 'ready' for therapy. When they first call, they are deeply distrustful of any human interaction, and they resist all attempts to help them. At the NATAL helpline, we respect these defenses, realizing that only gradually can we hope to form an alliance which leads to a sense of safety. The LIM offers an environment which is planned to provide constant therapeutic interactions and reaching out - an experience that is trustworthy, consistent and caring. Over time this predictable environment, in which communication is flowing, becomes a medium for healing. The helpline clients learn to trust the setting and the specialist as prelude to trusting other people and other situations.

To conclude, it is my belief that the combination of the medium (phone) along with the principles of the intervention (LIM) are responsible for the positive outcomes that were found during this research. The medium with its advantages are the basis which enables suffering and distrusting people to seek

help. The medium also enables clients to 'create in their minds' the desired helper, who can be their confidant and accompany them through the difficult journey toward healing. The elements of the LIM – longitudinal connection and reaching out, are encouraging the therapeutic alliance, which promotes healing and therapeutic gains. The synergy between the medium and the model creates a gestalt - a unified whole – a structure or formation possessing qualities that cannot be derived merely from the summation of its parts.

Chapter 15

Knowledge Sharing

'See others as yourself. See families as your family. See towns as your town. See countries as your country. See worlds as your world'.

Lao Tzu

(Mair & Tzu, 2012)

Thus far, the former chapters presented this research, the service which was investigated and the model which is suggested. This chapter presents the initial endeavors to share the knowledge and the know-how of these helpline and model. This thesis cannot be completed without exploring these preliminary efforts, and drawing some relevant insights. Undoubtedly, further research should be conducted to thoroughly investigate the generalizability and applicability of this model.

Knowledge-sharing in Israel

In 2004, after four years of massive terrorist attacks during which NATAL's helpline was very active and started to gain some reputation in the Israeli public, I was asked to write about our experience. Mental health professionals in the field of trauma were gathered to write together a book sharing their knowledge. The book is called "Mental Health in the Shadow of Terror: The Israeli Experience" (in Hebrew), and was published in 2005. The chapter titled "Telephone interventions following terrorist attacks" described the experience of two helplines – NATAL and ERAN, and was co-written by myself and by Eitan Tamir (Tamir & Haimov, 2005).

This was the first attempt to reflect on the helpline's work, its philosophy and the data accumulated by then. The emphasis was on crisis interventions, although some of the principles of the LIM were also presented.

After Operation Cast Lead, in 2009-2010, NATAL was asked to teach some of the principles of the LIM to professionals and volunteers, who had to provide emotional support to civilians living under prolonged stressful situations (continuous missiles attacks). This was the first time that the LIM was implemented (partially) beyond NATAL's helpline. Several municipalities provided their staff with this training, in the aim of equipping them with practical tools (which were found helpful) which

can be used in future crisis situations. Since then to this day, NATAL is involved in training all year long, in different locations around Israel and with different organizations.

This was an effort to share the knowledge and know-how with mental health professionals (especially professionals treating trauma), and with the Israeli public.

Knowledge has been defined as facts, information, and skills acquired by a person through experience or education (Zack, 1999; Davenport & Prusak, 1998). Another definition suggests that it is the theoretical or practical understanding of a subject, and an awareness gained by experience of a fact or situation (Oxford, 2009).

Knowledge is a fluid mix of framed experience, values, contextual information, and expert insight that provides a framework for evaluating and incorporating new experiences and information. It originates and is applied in the minds of knowers. In organizations, it often becomes imbedded in organizational routines, processes, practices, and norms (Davenport & Prusak, 1998; Ford & Chan, 2003).

A person or an organization can possess different types of knowledge: tacit and explicit (Boh, 2007). Explicit knowledge is easily articulated, coded, and transferred (Nonaka, 1994; Dhanaraj, Lyles, Steensma, & Tihanyi, 2004). Tacit knowledge is the "know-how", skills, and "practical knowledge" of organizational members (Choo & Bontis, 2002). Tacit knowledge is far more difficult to articulate and is derived from individual experiences (Matusik & Hill, 1998; Osterloh & Frey, 2000).

The knowledge that was sought from NATAL and me was both tacit and explicit knowledge. It spread over several areas and subject-matters. Naturally, it involved themes from the fields of trauma and phone interventions. It also involved crisis interventions and several therapeutic modalities (e.g. CBT). Furthermore, the demand was for the ability to combine them all. Spender (1992) argues that organizations are engaged not only in knowledge creation but also in knowledge application. The distinction between these two processes is crystallized in Demsetz's (1991) observation that efficiency in the acquisition of knowledge requires that individuals specialize in specific areas of knowledge, while the application of knowledge to produce goods and services requires the bringing together of many areas of specialized knowledge (Grant, 1996a).

Knowledge sharing refers to the provision of task information and know-how to help others and to collaborate with others to solve problems, develop new ideas, or implement policies or procedures. This can be done by documenting, organizing and capturing knowledge for others (Cummings, 2004; Pulakos, Dorsey, & Borman, 2003).

The need was for information – theoretical and practical. For acquiring routines, processes, and practices concerning trauma treatment, crisis interventions following war and terror attacks, and

phone interventions. It required the organization to take some steps to organize its knowledge in new ways. This process was described by Bowman, West, Berman and Van Wart (2016) as the articulation of organizational knowledge which requires abstraction. It involves creating cognitive categories to make sense of events, and then the new knowledge is absorbed and embedded in practice.

To sum, the external demand from other organizations to learn from MATAL's experience led NATAL to better conceptualize and construct its knowledge, in order to be able to deliver it outside the boundaries of the organization. The training which was formed and dlivered by NATAL equips professionals and laymen to carry out phone interventions with people who experience trauma – as crisis interventions and also as continuous interventions following the crisis (according to the LIM). Most of the organizations which were trained by NATAL offer these services as ad hoc ventures and none of them offers a long-term helpline.

The above described events triggered an insight with NATAL's management – for some time the management was looking for ways to make changes in the organization's budget, which rely almost exclusively on donations. It came to the conclusion that the organization needs to rely more on selling services – and this external demand was found to be the opportunity the organization was looking for.

This trend is reflected by Hall (2006) who suggested that the resource base of nonprofits has become diverse. While there are still many organizations supported by donations and endowment income, other nonprofits are wholly dependent on the sale of goods and services, grants and contracts. Once wholly dependent on contributions to defray capital costs, today nonprofits not uncommonly finance physical expansion through the sale of services.

Similar process is described by scholars who found that knowledge is a critical organizational resource which provides a sustainable advantage in a competitive and dynamic economy (Davenport & Prusak, 1998; Foss & Pedersen, 2002; Grant, 1996a,b; Wang & Noe, 2010). Additionally, Harris (2001) suggested that knowledge as a resource is contained within the minds of employees, and is possibly the only resource that, when used, can enhance the value of other capital and does not diminish in value.

NATAL realized that the avenue of providing training alongside providing mental health treatments can improve the organization's financial situation. Additionally, NATAL realized that the helpline with its experience, expertise and reputation is a sought commodity and can serve as a source of income.

Knowledge-sharing in the U.S. - WWP

After providing specialized helpline training in Israel, another opportunity presented itself. NATAL has a sister organization – AFN (American Friends of NATAL), which supports its activity (mainly by fundraising). AFN also engages in innovative collaborations, partnering with US organizations who seek NATAL's expertise in the field of trauma preparedness and recovery.

In 2011, a connection was made with an American organization - Wounded Warrior Project (WWP). This is one of the fastest growing non-profit organizations in the US, whose mission is to honor and empower wounded warriors, specifically by helping post 9/11 service members struggling with physical and mental injuries.

The two organizations (NATAL and WWP) share some similar core values – they both treat combat soldiers who were injured, physically or mentally, during their military service. Both organizations believe it is society's duty to care for those soldiers and also acknowledge the grave implications PTSD has on the soldiers, requiring rehabilitation. These similarities were the basis for collaboration.

Yet, there are also many differences, among which are the different role of the military in the society and the different standing and attitude towards soldiers. Another major difference between the organizations is that WWP is involved in rehabilitation and financial empowerment, without attending to the psychological aspect of the injury, while NATAL is involved almost exclusively with the mental health aspect of the injury without attending to the financial/occupational aspect.

Considering their reluctance to get involved with mental health issues, WWP thought that NATAL's helpline may serve as a good resource which can provide answers to the psychological needs of their clients without being considered as 'mental health' per se.

Therefore, during three years of collaboration (2012-2014), NATAL and the Wounded Warrior Project have launched a Helpline, modeled after NATAL's Helpline in Israel, to help American veterans suffering from PTSD.

This venture and others like that are defined as "inter-organizational knowledge transfer" by Maurer, Bartsch and Ebers (2011) and Fang, Yang and Hsu (2013). Similarly, Windrum (2014) suggests that they are collaborative alliances which bring together and develop complementarities and synergies between the specialist knowledge, competences, services, and financial resources of each partnering organization. Sharing sometimes involve an active formal and sustained partnership, such as the sharing of practices, policies and expertise between organizations (Rathi, Given, & Forcier, 2014). The most common variety of inter-organizational collaboration is when nonprofit organizations collaborate with each other, creating a web of information and resource sharing (Vangen & Huxham, 2003).

The motivation driving this trend is portrayed by Myers (1996) who argued that organizations often find it too costly and cumbersome to develop, on their own, all the knowledge and capabilities they

need or want to have available. In response, many of them are creating knowledge links – alliances which give them access to the skills and capabilities of other organizations and sometimes enable them to work with other organizations to create new capabilities.

In sum, inter-organizational relationships are voluntary efforts of two or more organizations to create and maximize their joint value (Choi & Lee, 1997).

NATAL and WWP believed that a collaborative alliance can benefit both organizations; it enables NATAL to sell its service and bring in needed money for the organization. Additionally, it promoted the reputation of the organization – as Shenkar and Yuchtman-Yaar (1997) suggest, prestige is defined as a reputation arising from success or a favorable and publicly recognized name for merit achievement. Becoming a familiar name is an indication that the organization has moved from particular to universal existence.

This alliance also benefited WWP by enabling it to utilize the experience and expertise accumulated for many years in NATAL, to introduce a new service to their clients.

During this multi-year partnership, NATAL's experts provided on-site support, guidance and dedicated insight to determine the needs and best practices for a US based model. The collaboration culminated in WWP successfully launching its own pilot helpline in Jacksonville, Florida. The Helpline is designed specifically for U.S. veterans and suited to meet their needs.

From an organizational standpoint and a personal perspective this project was a huge challenge. It required seven visits of the Israeli team to the US and two visits of the American team to Israel. It involved physical and psychological struggles, and more than anything, it necessitated flexibility and sensitivity. Despite the similarities there were many cultural differences to overcome.

According to Ford and Chan (2003), different national cultures emphasize different and distinct values. Also, a person's healthcare is influenced by cultural and ethical values and attitudes (Beauchamp & Childress, 2009; Bhui et al., 2003; Ekman & Emami, 2007).

To achieve cultural sensitivity, one must have knowledge of cultural differences and values (Foronda, 2008; Josipovic, 2000; Kane, 2000; Parfitt, 2004; Percival & Black; 2000; Wasson & Jackson, 2002; Wilson, Baker, Brown-Syed, & Gollop, 2000; Zoucha, 2000).

Moreover, cultural sensitivity involves tailoring a mindset or action to fit or match the recipient (Harris et al., 2001; Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000; Scorzelli & Reinke-Scorzelli, 2001).

This project required to first learn the American culture, then to gain understanding of the American military, soldiers and veterans, and also to develop awareness to social norms and expectancies.

Only then it was possible to try and adapt the helpline model and the training to suite the client (WWP) and its clients (wounded veterans).

NATAL's team had to acknowledge and deal with the difficulties of transferring knowledge across what Carlile (2002) terms “knowledge boundaries,” by which he means differences in knowledge that is localized, embedded and invested in different practices, and which inhibits coordination between expert groups possessing different forms of expertise (Majchrzak, More, & Faraj, 2012). To demonstrate that, two examples are presented:

NATAL's experience showed that in order to provide good quality interventions, it is important to work with good helpline specialists – which require a thorough selection process. The American team understood and accepted this principle, yet was restrained by American HR (Human Resources) regulations which didn’t allow exploring many of the areas the Israeli team thought necessary. After an intensive struggle and much deliberation, a creative solution was found – the American team explained to the American candidates that they are going to be interviewed by Israelis who have different culture, norms, and regulations. Therefore, they may ask 'inappropriate' questions – which the candidates are not required to answer. Only then, the Israeli team did the actual interviewing (and asked the 'inappropriate' questions), and to everyone's surprise got the answers to all the questioned asked...

Additionally, we found that independent of culture, humor is a great icebreaker – we proclaimed ourselves as 'the rude Israelis', apologizing in advance for the possibility of us being impolite according to their culture, and asking them to let us know when we cross the line. They all smiled and said they have nothing to hide – allowing a flowing non-restricted interview.

The American team realized the importance of the information we discovered through deep interviewing, yet was limited and unable to do that themselves. Therefore, it was jointly agreed that throughout the entire project, the candidates were selected by the Israeli team.

Another example is the reluctance of the American team to use the term PTSD (Post Traumatic Stress Disorder). Anything that might be perceived as 'clinical' was forbidden and the Israeli team had to change and eliminate parts of the theoretical training to accommodate the American standpoint.

As shown by the literature, we also learned that coordination between different cultural groups involve the creation of shared understandings (Vlaar, van Fenema, & Tiwari, 2008), and the transformation rather than the transfer of knowledge (Bechky, 2003; Carlile, 2004).

This joint venture ended in the end of 2014, after three years of close collaboration, when WWP started to operate independently their helpline. The relationship between the organizations and the teams involved are good to this day. Additionally, the success of this project became the stepping-stone to another American venture, which will be described next.

Knowledge-sharing in the U.S. – Chicago

In 2015, NATAL was invited to Chicago by the newly formed TURN center (The Urban Resiliency Network) in Bronzeville and Sinai Health System. The Urban Resiliency Network was launched by Pastor Chris Harris, in 2014, in partnership with University of Chicago Medicine, Northwestern University Medicine, United Way and the Jewish Federation of Metropolitan Chicago (JUF). TURN is dedicated to serving Chicago with counseling and other social services aimed at minimizing negative factors that cause violence while increasing protective influences that yield positive outcomes.

This time NATAL has embarked on a large project in Chicago – to assist in the development of trauma and resiliency centers in areas of the city affected by urban violence.

The Chicago team visited Israel, during which it also visited NATAL. They believe that in the inner city of Chicago, like in Israel, Chicagoans are at risk of psychological trauma, due to the high prevalence of violent crimes in Chicago,

In 2016, Chicago experienced its deadliest year in almost two decades. According to Chicago police, 762 people were killed, an increase of 58% from 2015. According to The New York Times, Chicago had more criminal homicides this year than New York and Los Angeles combined, despite having fewer residents than either city (Martinez & Kovar, 2016).

TURN's team felt that living in Chicago nowadays, being exposed to daily shootings and violence, is very similar to what many Israelis experience – which results in traumatic stress. They wanted to do more than learn from NATAL's experience – they wanted to replicate the whole organization. After a year of preliminary work, which included mutual visits, an analysis and needs assessment, and once initial funding was obtained, this collaborative alliance could be actualized.

It was decided that the first step should be a helpline. NATAL is to help building the necessary infrastructure for TURN's Helpline, as well as a 5-week intensive training of the first cohort of helpline specialists and mental health professionals to provide pre-clinical counseling to individuals who may be in need.

This project requires NATAL to adapt its helpline model to different target population, to different culture and to different subject-matter. The future helpline should serve African-American residents of the most violent neighborhoods and communities in Chicago, who experience urban violence. It

seemed that nothing can be more different and further from NATAL's Israeli mission. There are three inherently major differences between the two populations: (a) the characteristics of the population, (b) the violence and the resulting trauma, and (c) social group.

The African-American community has different characteristics than the Israeli with regards to race, religion and nationality.

While Israelis cope with terror, they cope with different type of violence. In Israel, the perpetrators belong to a different social group (they are Arabs, Muslims), while in Chicago the perpetrators belong to the same social group (they are also African-Americans).

Lastly, Jews are the majority group in Israel, while African-Americans are a minority group in the US.

Coming into this project I was very worried with all these differences. The fear was that it will be impossible to understand each other, accept each other and to bridge the dissimilarities. As a coping mechanism, I took it upon myself to learn as much as possible about African-Americans, hoping it will bring understanding and help with cultural sensitivity. The more I learned the more I discovered that despite all the differences described above, there were many similarities to be found.

Historically, people of African descent and the people of Jewish descent have been among the most consistent, prominent, and public targets of hatred, discrimination and oppression (Lerner & West, 1995).

In the past, Jews were considered blacks/Africans: 'Jews belong to the dark races of men. They are dark, and their whole physiognomy has an African look. Their qualities are unmistakably like those of the African savage: no inventive power, no mechanical or scientific turn of mind ... no love of science or literature' (Knox, 1969).

The shared histories of oppression have shaped the lives of generations of Blacks and Jews. These histories of oppression contributed to shared values, such as social community responsibility and identification with the "underdog" (Adams & Bracy, 1999; Kaufman, 1995; Lerner & West, 1995).

The similarities in the history, the resulting trauma, and the resemblance of values and attitudes helped to ease the discomfort brought by the differences. Moreover, the awareness to these similarities helped to create instant bonds and closeness.

Today, African-American communities deal with problems which are a consequence of multigenerational oppression of Africans and their descendants, resulting from centuries of slavery, which then were followed by institutionalized racism that continues to perpetuate injury (DeGruy, 2017; Leary, 2005). In Chicago, high levels of violence affect individuals and communities and cause psychological distress, trauma and loss.

The major objectives of this project are to equip TURN's staff with the tools, knowledge, attitudes, and skills required to perform the task of a helpline supporter, the expertise to provide trauma informed interventions within their community and to serve as a pillar for community resilience.

A helpline service can provide a necessary solution to this troubled population, serving as a bridge to mental health treatment for people in a culture which is reluctant to use such services (Clement et al., 2015; Cheng et al., 2013).

Over the next year NATAL will continue supporting and training TURN as they lay the foundation and launch the Helpline. From strengthening their infrastructure abilities, to supporting the professional staff, as well as, providing further training to TURN staff in Chicago to be able to provide a range of different trauma informed interventions to their communities.

To conclude, the non-profit sector encompasses all the organizations aimed at creating social value for society as a whole, and which do not recognizes as their main goal the creation of profit for stockholders (Borzaga & Santuari, 2000; Lester, 1999; Ryan, 1999; Rifkin, 1995). In today's economy, nonprofit organizations must become more innovative and find alternative ways to stay sustainable.

One way to gain advantage and enhance organizational effectiveness is through the formation of inter-organizational relationships with other nonprofit organizations (Mulroy & Shay, 1997; Powel, 1990; Reisch & Sommerfield, 2003; Jaskyte & Lee, 2006). In fact, observers assert that the frequency of collaborative relationships between nonprofit organizations has been increasing in recent years (Guo & Acar, 2005; La Piana, 2000), and collaboration is becoming fairly common (Vangen & Huxham, 2003).

NATAL's efforts to form collaborative alliances with nonprofit organizations in the US are targeted to achieve organizational advantages in terms of prestige and finance.

Yet, one of the major challenges of inter-organizational knowledge transfer is the boundaries that separate the parties, which involve national cultural differences that are related to the ongoing trend of globalization (Easterby-Smith et al., 2008). In fact, Inter-organizational knowledge transfer partners suffer from their organizational and national culture differences especially if they are from different countries (Ford & Chan, 2003; Chen, Duan, Edwards, & Lehaney, 2006).

Indeed, when collaboration is initiated in the context of evolving knowledge across multiple cultures, conflicts and misunderstandings emanate. LaBahn and Harich (1997) emphasized the importance of cultural sensitivity in international collaborative ventures (Chua, Morris, & Mor, 2012), and Vangen (2016) suggests that learning how to work with cultural differences is important if collaboration is to yield advantage rather than inertia.

Working on both joint ventures in the US, a lot of effort was made to develop cultural sensitivity and to overcome natural barriers. It is important to acknowledge that similarities were found in unexpected circumstances, and also differences appeared where similarities were anticipated.

The mutual satisfaction of both organizations during these projects can attest to the quality of the bond which was formed by the individuals involved in the projects. According to Buckley, Clegg and Tan (2006), for explicit knowledge to be transferred and absorbed, cultural barriers have to be removed and good inter-partner relationships have to be established (Hong, Heikkinen, & Salia, 2009).

The two organizations NATAL collaborated with in the US are very different from one another. One of them seems more similar to NATAL (WWP) and the other seems more different (TURN). However, this perceived resemblance and difference were found irrelevant to the quality of the relationship formed, or to the success of the project. Surprisingly, the African-American culture was found (by us) to be more similar to the Israeli culture than the Caucasian-American culture, resulting in a closer, warmer relationship. Additionally, TURN and NATAL are small organizations with unformal organizational culture, while WWP is a very large organization with formal organizational culture – a character which probably also affected the relationship formed.

It is reasonable to assume that many variables affected the collaboration, the relationship, the knowledge transfer and the success (or potential success). Windrum, Reinstaller and Bull (2009) propose that innovation networks are formed purely on the basis of skill fit between the partners. Partners which are too similar have nothing to learn or contribute to one another, so a degree of competence differentiation is important. However, if the cognitive distance is too great then there is no absorptive capacity and partners cannot work with, or learn from, each other. It seems that there were some similarities and some differences between NATAL and the American organizations, which enabled learning and cooperation.

The importance of such knowledge transfers has bearing on different aspects. First, it allowed testing the helpline model in different settings, with different cultures and different populations. Although formal research hasn't been made, this experience suggests that the LIM can be successfully implemented in different organizations, countries and cultures.

Secondly, it reinforced the conclusions of existing literature, that manmade trauma, although varied (e.g. violence, terror attacks, and wars), has universal characteristics (De Jong, Knipscheer, Ford, & Kleber, 2014; Lee, Na, & Sim, 2015; Leaning & Guha-Sapir, 2013). Additionally, manmade disasters have been found to cause more long-lasting psychological after-effects than natural disasters (Riaz et al., 2015; Taylor, 2016). Therefore, it strengthens the awareness to the devastating effects of manmade disasters, and the need to provide healing and rehabilitation.

Thirdly, it reinforced the findings of existing literature regarding help-seeking barriers, which according to Ingram et al. (2008), are evident all over the world. The three organizations, NATAL, WWP, and TURN operate in different locations and serve different populations – all struggling with the stigmatization of mental health treatments and consequentially with the discrepancies between those who need help versus those who receive professional treatment (Campos, 2009).

This also raises the question of how to attract those people who are in need of help but are resistant to seek out assistance – a question which is answered by the suggestion to widen the array of available avenues to mental health services (Ingram et al., 2008), and the conclusion of Lester and Rogers (2012), that a telephone counseling service is, perhaps, the only means by which such individuals can receive help.

Finally, the two attempts to transfer the knowledge accumulated in NATAL's helpline, and to implement the LIM in varied settings may serve as the beginning of a process leading to the promotion of better understanding of the potential role helplines can have in trauma treatment. Such ventures were defined by Fataneh and Shirley (2007) as activities that support collaboration among practitioners, which can promote the creation of knowledge that is current and relevant. Each knowledge-sharing and every time the LIM is implemented; it leads to another development and contributes to the knowledge in this field. Once the current project in Chicago comes to an end, it is worth to conclude it with a research. Maybe another thesis can be written, dedicated to these knowledge sharing activities and implementations.

Chapter 16

Conclusions and Reflections

Conclusions

'There is only one way to learn. It's through action. Everything you need to know you have learned through your journey'.

Paulo Coelho

(Coelho, 1988)

This research investigated an Israeli helpline (NATAL's helpline) which provides treatment to survivors of trauma and loss, and operates on the basis of a unique model of intervention – the LIM.

Israeli society has been coping for years with multiple-victim incidents, outcomes of terror and wars. This coping produces psychological reactions in various levels–trauma, anxiety and bereavement– spanning substantial parts of society (Doron et al., 2006). Yet, the recent unrest and protests that raged across countries and continents show that the greatest problem the world is facing today is terrorism in one form or another (Husain, 2012). Western countries have started to realize that their populations are and will continue to be affected by terror and its mental health effects. Therefore, although this research originated from a narrower starting point – investigating a service for Israelis affected by terror and war, it is now addressing a larger more global phenomenon.

Events of trauma and loss create tremendous changes in one's life, undermine one's fundamental values and meaningful relationships and create difficulties and challenges for oneself (Schaefer & Moos, 2001). Strenger (1999) maintained that (from Hebrew) ''The Trauma is engraved so deeply in one's mind that the person feels as if their wholeness is always in danger.'' Also some losses are so painful that the mourner is convinced they will never overcome them, and in fact, not everyone can return to full and productive living following a loss (Rubin, 1999), and some people never get over loss and never rehabilitate (Davenson, 2004).

This work presents a helpline's operational model, which was developed in recognition of the unique damage caused to victims and the repercussions of national/collective trauma. It is also guided by an approach which connects the nature of the psychological injury to the mode of the rehabilitation: Brom et al. (1993) stated that the process of coping with loss and trauma is based on reintegration and creation of new relationships. Herman (1994) expanded on their ideas and maintained that the kernel of the experience of psychological trauma is the stripping of power and disconnection from others, which is why healing should be based on empowerment and creating new relationships.

Therefore, rehabilitating victims of trauma or loss is reliant upon encountering and reconnecting the victim with others, whether in the victim's natural environment or with the help of a therapist. However, victims of trauma find it difficult to meet new people and trust them enough to open up to them (Follette, Ruzek, & Abueg, 1998) and thus avoid asking for help of any kind, not to mention psychotherapy (Herman, 1994). It is vital that victims of trauma or loss speak to someone for support, because when they are able to share their problems with others and accept support from them, they will feel less lonely and more understood, and in many cases will be able to receive actual help.

Additionally, the stigma attached to mental treatment prevents many people from receiving help, especially in the setting of the Israeli culture: ''In Israeli society, the stereotype of a person who gets therapy as someone who is weak or 'screwed-up' is still quite common'' (Strenger, 1999, p.38).

Dissimilarly, McLeod and Wright (2009) suggest that today we live in a therapeutic culture, characterized by talk-shows, best-selling autobiographies, and the proliferation of self-improvement books. All these point to the imperatives of talk and self- disclosure, the privileging of the psychological and emotional realms, and a heightened concern with the self and interior life. Therapeutic modes of thought thus extend beyond the clinical encounter, influencing everyday interactions and practices.

One could wrongly expect this therapeutic culture to also be accepting of mental health problems and to encourage therapy. However, it seems that the opposite is true - the majority of individuals with mental health problems remain untreated, and public stigma about mental illness has either remained steady or worsened over time (Angermeyer, Holzinger, & Matschinger, 2009; Pescosolido, et al., 2010), resulting in declining rates of treatment with psychotherapy (Marcus & Olfson, 2010).

This problem may be overcome by services that provide psychological help via the telephone, which requires less effort and strength than other methods – because it enables anonymity, privacy and control, and does not demand a high level of trust.

Additionally, despite recent technological development and the overabundance of information widely available on the internet, Firth et al. (2005) found that people still retain a desire, or, indeed, experience an increased desire, to talk to and engage with someone in their search for help.

The field of telephone therapy is progressing impressively (Baker & Bufka, 2011) and it has huge potential as a tool for providing psychosocial services to populations from various cultures and ethnicities (Al-Karnawi et al., 2003). The telephone is available and accessible to almost everyone in the world, including Israel; in 2014, for the first time ever, there were more mobile phones in the world than there were people (International Telecommunication Union, 2015). As of today, seven

billion people (95% of the global population) live in an area that is covered by a mobile-cellular network. In Israel, 93.6% of the citizens own a mobile phone (Israel Central Bureau of Statistics, 2017).

According to the GSMA no other technology has impacted us like the mobile phone. It is the fastest growing manmade phenomenon ever - from zero to 7.2 billion in three decades (GSMA Intelligence, 2017).

There exists full consensus regarding the many advantages offered by telephone helplines; however, practitioners are at odds regarding the appropriate use of the telephone in therapy (Harwood et al., 2011). In light of studies that showed that the number of people who turn to telephone counseling is similar to the number of people who turn to face-to-face therapy (Dorstyn, Mathias, & Denson, 2011), there is a need to develop models for telephone interventions in order to set professional guidelines and train practitioners in this field.

Hopefully, this work will serve as an additional reinforcement to the need of a conceptual change in the field of mental health – the time has come to stop burying the head in the sand and to promote embracing technology into this field. It is time to realize that not only technology doesn't have to obstruct human contact – it can even promote human connections.

Coman et al. (2001) maintained that even when a telephone service is intended just for providing information; it still serves as a connection point for receiving face-to-face therapy. Similarly, the first motivation for establishing the NATAL helpline stemmed from the desire to allow those contacting the organization easy and fast connection to the clinical unit, in order to receive face-to-face therapy. However, while building the professional infrastructure for the helpline, it emerged that there was a need for constructing a unique intervention model, which would be better suited to the various needs of trauma and loss survivors.

This thesis presents the Longitudinal (telephone) Intervention Model, which is a service provided to the same person over time, during which the caller gets to know the helper and speaks to the same helper every time. In this way, a deeply human and caring encounter between people takes place, which is the heart of psychological therapy (Guntrip, 1996; Yalom, 1989).

Many scholars referred to the importance of the therapist attitude and the therapeutic relations (Rogers, 1957; Satir, 1988), for example, Fife, Whiting, Bradford and Davis (2014) discussed the term 'way of being', which refers to the in-the-moment attitude that therapists have toward clients and provides a foundation for the therapeutic alliance. This attitude can be genuine and open to the humanity of the client, or it can be a stance that is impersonal and objectifying. Additionally, Corey (2005) argued that the humanity of the therapist is critical for connecting with clients and suggests that if "we hide behind the safety of our professional role; our clients will keep themselves hidden

from us” (p. 17). Because therapy is a human rather than a technical endeavor, it requires an authentic human relationship facilitated by “our own genuineness and aliveness” with our clients (Corey, 2005; p. 17).

It is not my intention to suggest that a helper/specialist/therapist only needs to be nice, warm, compassionate, and accepting in order to achieve successful treatment. Obviously, knowledge, skills, and techniques are essential to successful practice. However, it is evident that there is some truth to the reputation mental-health treatments have, and this causes many people to refrain from seeking professional help. Unfortunately, many professionals take an elitist, all-knowing approach, believing they are maintaining professionalism. In Israel, we are witnessing a growth of mental health professionals trained as psychoanalysts, being oblivious to the fact that most people cannot afford five therapy sessions a week (economic wise or due to time constraints). Similarly, many of the health institutions and insurance companies force therapists to be trained and practice evidence-based therapies, which are designed to be short and less expensive, yet are not suitable for many clients and some mental problems.

My suggestion is twofold; first, to increase the roles of paraprofessionals performing social tasks in the fields of health, mental-health, social work, and education. This will not only reduce costs, the burden of mental illness, but also will enable to provide services to untreated populations, due to stigma or lack of finance. Second, to encourage mental health professional theorists and practitioners to find innovative ways to de-stigmatize treatments, to make treatments more accessible and more affordable, and to collaborate with paraprofessionals - thus allowing more people to engage in treatment, and promoting individual and communal well-being.

This intervention model works towards creating as wide an infrastructure as possible for rehabilitation and improving the quality of life of victims of trauma or loss. This requires targeted intervention work which rests on a professional rationale.

It might be expected that the prevalence of helplines in Israel and around the world and the substantial developments in this field would lead to clear professional models for telephone interventions, however, it was found that only in 47% of studies conducted on telephone therapy services was there a theory or model serving as basis for the telephone intervention identified (Hutchison & Breckon, 2011).

This thesis presents a theory-based operational model for which the findings of an assessment study were presented herein, indicating that indeed it does help improve survivors’ quality of life and their rehabilitation. Also, it indicated that the helpline impact is in reaching the target population and engaging with resistant untreated people.

The findings presented earlier show that based on this model, during the longitudinal phone intervention; significant therapeutic relations are formed, which serve as a foundation to a process of change and improvement. Also, it was shown that this intervention, which applies eclectic psychological approaches, successfully promoted symptoms reduction and better functioning of clients. Similarly, this investigation found that both the service users and the service providers found the intervention to be helpful.

It is my conclusion, that the helpfulness of the intervention is based on two main factors: (a) the LIM and its characteristics, and (b) the medium, phone, with its advantages. This conclusion can be related to Isaacs's (1993) term ‘metalogue’. “Metalogue reveals a conscious, intimate, and subtle relationship between the structure and content of an exchange. According to Isaacs (1993), the medium and the message are linked (van Loon & van Dijk, 2015). Therefore, the positive outcomes that were found in this research may indicate that NATAL's helpline created a metalogue, and can also suggest that helplines should aim for creating metalogue.

In a sense, the findings of this study can be classified as preliminary, since this study points to the need for more study. The task now is to further study phone interventions more closely, and with phenomenological contributions from both specialists and clients, to understand why, how, and when longitudinal phone interventions should be provided. This can outline best practices, and thus becoming a cornerstone of tele-medicine theory and delivery.

Also, my hope is that the findings and ideas emerging from this thesis will stimulate additional reflection and broader dialog on the foundations of therapy, therapeutic approaches and therapists' attitudes, as well as on the potential roles and practices of paraprofessionals.

Finally, this thesis will hopefully provide inspiration for other organizations and helplines to implement this model in the field, along with research work for its further validation. I believe that based on the rationale of this model, other models for continuous telephone interventions may be proposed for similar population groups, e.g., sexual trauma, child abuse, traffic accidents and more.

Reflections

Standing at the finish-line and writing the final words is an emotional moment, generating many contrasting feelings; fatigue and excitement, confidence and uncertainty, happiness and sadness. My feeling can be summed by the words of T.S. Eliot (2009):

'What we call the beginning is often the end
And to make and end is to make a beginning.
The end is where we start from'.

T.S. Eliot

Writing this thesis is indeed a personal milestone. In hindsight, it is not only a reflection and synopsis of my professional work in the past 27 years; it is also a reflection and synopsis of my entire life and experiences in the last 50 years.

One of my earliest memories is a feeling, not an experience - it was the need I felt to comfort someone who was sad and upset. I remember this feeling very vividly, and remember actively starting to comfort that person without hesitation. In spiritual words, it was as though I was born to comfort people. This primal feeling is one of the roots for choosing my career - sometimes being open to another's humanity occurs spontaneously, as when we feel compassion or concern for another's distress, but other times it is a conscious choice to try to see the other's reality.

From an early age to this day, I am fascinated by the mystery of the world and humankind. I feel the need to explore, reveal and learn more. This journey provided me with a fantastic opportunity to reflect, to learn and to grow – for which I am grateful. In professional terms, this work led me to another exploration of the concept of therapy/treatment. Ever since I started studying for a Bachelor degree, I tried to find a stance which feels comfortable for me – clinical psychology felt too clinical and at times cold. Social work felt more comfortable, yet at times, for me, provided more practical practices than deeper insights and understandings. I found a comfortable area in existential psychology and meaning-making, yet I am still searching for an answer to the timeless question: 'what is it the healing factor? What should happen in therapy so that it is successful?'

According to Kazdin and Blase (2011), we know well that therapy "works," i.e., is responsible for change, but have little knowledge of why or how it works. It is remarkable that after decades of psychotherapy research, we cannot provide an evidence-based explanation for how or why even our most well studied interventions produce change. Therefore, this study is part of my quest to find that answer.

I believe that while searching for an answer it is very important to be cognizant of the *Rashomon effect*. The *Rashomon effect* is where the same event is given contradictory interpretations by different individuals involved (Anderson, 2016; Roth & Mehta, 2002). This is a life lesson I thought I learned, but rediscovered it again during this research - a positivist search for truth versus error may be less fruitful than a constructionist examination of the research itself.

One of the most important lessons I have learned from this study was to look past a thesis and antithesis to create synthesis; similar to one of the principles of the gestalt, one can see the figure or the background. I started this project with awareness to what I was taught as 'right' or 'wrong' in terms of therapy, which wasn't always consistent with my field experience. Therefore, I thought I formulated a philosophy which was consistent with my experience, thus must be inconsistent with some of the theory and practice. I mistakenly thought that the model I developed is stranger to both traditional therapy and crisis phone interventions. Later in my research I realized that this model is indeed unusual, but not because it is different – it is because it is similar. This model is a synthesis of both traditional therapy and crisis phone interventions – and as such, it can take some of the best elements from both to create another good option

The current segment of my professional journey deals with national trauma. Collective trauma/national trauma is a relatively new concept in psychology. Similarly, longitudinal phone interventions are a new mode of treatment. Both ideas stem from the recognition of people's suffering, and the necessity to find a response to this suffering. I believe that any groundbreaking work (in any field) originates from professionals acknowledging a situation, and initiating a discourse which leads to the formation of theory. This theory is then tested in real-life situations, and investigated through research, so that it can be established as a professional stance. This is a positive process since it can lead to development.

Fortunately, as Warner and Olson (1981, p. 501) suggested, we are often guided in our professional roles more by our deep human responsiveness to people than by our theories. As a result, good things frequently happen. My work and interest in trauma and therapy started long before I have personally experienced either. Yet, my current work is largely shaped by my own experience of trauma and loss.

I am aware to the fact that joining an organization helping trauma survivors and building this helpline were motivated by my own grieving process and the need to find meaning. As the Dalai Lama (Dalai Lama & Cutler, 2009) proposed, when we meet real tragedy in life, we can react in two ways - either by losing hope and falling into self-destructive habits, or by using the challenge to find our inner strength. For me, the way toward healing was through doing good for others and help them also heal. It was a choice – choosing life, and not an easy choice, but it enabled me to break free from the pain, the emptiness and the pessimism, and instead focus energy in positive actions.

At a certain moment, in that crossroad, I reconnected to that child who felt the need to comfort someone in distress. I reconnected to my inner therapist/healer, who feels a profound commitment to the well-being of others. By reconnecting to my core being I was able to help others reconnect to themselves.

So, writing this thesis was a personal milestone, and also forced me to reflect again on my loss, the grieving process and the healing. Being so engaged in the theme of my writing had many advantages but also some drawbacks.

This research was at times an emotional roller coaster. Although I am very much aware of the situation and its emotional toll, and I am aware of my emotional wounds as an individual and as an Israeli – it was emotionally flooding at times. I think that writing and describing certain experiences was reactivating the original experiences and at times even opened some old wounds.

However, in personal terms, the most important lesson I have learned from this study is the significant therapeutic impact writing has for me. Through this process I have experienced so much pleasure in reflecting and learning. I gained many new insights and expanded my understanding and practice. Yet, the greatest gift was the joy of writing – molding ideas to words, threading words to strings of sentences, and then finally weaving it all into a fabric.

It was bliss to write, and also a blessing. I wrote my past, my present and my future. It was therapeutic. Then, it reminded me that after the loss of my best friend, Yael, I found comfort and outlet in writing poems. It helped in my grieving process. In the words of the poet Szymborska (2015): *'The joy of writing. The power of preserving'.*

This experience taught me that I write out of a need to preserve. It allows me to paint what I saw and experience for others to also see and feel. It helps me to battle the mortal and the temporary by turning them to timeless. The final words are borrowed from Kahlil Gibran (2013):

The timeless in you is aware of life's timelessness,

And knows that yesterday is but today's memory and tomorrow is today's dream.

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